Medicare Claims Processing Manual
Chapter 18 - Preventive and Screening Services

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(Rev. 795, 12-30-05)
(Rev. 895, 03-24-06)

Crosswalk to Old Manuals

10 - Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines

(Rev. 1, 10-01-03)

SNF-536.2, B3-4480, A3-3660.7, A3-3110 (partial), A3-3157 (partial), A3-3192 (partial), SNF-534.A, RHC-614, HSP-303.6.A, B, HO-435.A, HHA-473.A, B, HO-230.4.C, RHC-404

Part B of Medicare pays 100 percent for pneumococcal pneumonia vaccines (PPV) and influenza virus vaccines and their administration. For carriers, Part B of Medicare pays 100 percent of the Medicare allowed amount for pneumococcal pneumonia vaccines (PPV) and influenza virus vaccines and their administration.

Part B deductible and coinsurance do not apply for PPV and influenza virus vaccine.

Part B of Medicare also covers the hepatitis B vaccine and its administration. Part B deductible and coinsurance **do** apply for hepatitis B vaccine.

See the chart in Chapter 16.

State laws governing who may administer PPV and influenza virus vaccinations and how the vaccines may be transported vary widely. Intermediaries (FIs) and carriers should instruct physicians, suppliers, and providers to become familiar with State regulations for all vaccines in the areas where they will be immunizing.

10.1 - Coverage Requirements

(Rev. 1, 10-01-03)

SNF-536.2.A, B3-4480, A3-3660.7, 3110, 3157, 3192, SNF-534.A, RHC-614, HSP-303.6.A, B, HO-435.A, HHA-473.A, B, HO-230.4.C, RHC-404

Pneumococcal vaccine (PPV), influenza virus vaccine, and hepatitis B vaccine and their administration are covered only under Medicare Part B, regardless of the setting in which they are furnished, even when provided to an inpatient during a hospital stay covered under Part A.

See the Medicare Benefit Policy Manual, Chapter 15, for additional coverage requirements for PPV, hepatitis B vaccine, and Influenza Virus vaccine.

10.1.1 - Pneumococcal Pneumonia Vaccine (PPV)

(Rev. 1, 10-01-03)

Effective for services furnished on or after July 1, 2000, Medicare does not require for coverage purposes, that a doctor of medicine or osteopathy order the PPV vaccine and its

administration. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

See the Medicare Benefit Policy Manual, Chapter 15, for additional coverage requirements for PPV.

A. Frequency of PPV Vaccinations

Typically, PPV is administered once in a lifetime. Claims are paid for beneficiaries who are at high risk of pneumococcal disease and have not received PPV within the last five years or are revaccinated because they are unsure of their vaccination status.

An initial PPV may be administered only to persons at high risk (see below) of pneumococcal disease. Revaccination may be administered only to persons at highest risk of serious pneumococcal infection and those likely to have a rapid decline in pneumococcal antibody levels, provided that at least five years have passed since receipt of a previous dose of pneumococcal vaccine.

B. High Risk of Pneumococcal Disease

Persons at high risk for whom an initial vaccine may be administered include:

- All people age 65 and older;
- Immunocompetent adults who are at increased risk of pneumococcal disease or its complications because of chronic illness (e.g., cardiovascular disease, pulmonary disease, diabetes mellitus, alcoholism, cirrhosis, or cerebrospinal fluid leaks); and
- Individuals with compromised immune systems (e.g., splenic dysfunction or anatomic asplenia, Hodgkin's disease, lymphoma, multiple myeloma, chronic renal failure, Human Immunodeficiency Virus (HIV) infection, nephrotic syndrome, sickle cell disease, or organ transplantation).

Persons at highest risk and those most likely to have rapid declines in antibody levels are those for whom revaccination may be appropriate. This group includes persons with functional or anatomic asplenia (e.g., sickle cell disease, splenectomy), HIV infection, leukemia, lymphoma, Hodgkin's disease, multiple myeloma, generalized malignancy chronic renal failure, nephrotic syndrome, or other conditions associated with immunosuppression such as organ or bone marrow transplantation, and those receiving immunosuppressive chemotherapy. Routine revaccinations of people age 65 or older that are not at highest risk are not appropriate.

Those administering the vaccine should not require the patient to present an immunization record prior to administering the pneumococcal vaccine, nor should they feel compelled to review the patient's complete medical record if it is not available. Instead, if the patient is competent, it is acceptable for them to rely on the patient's verbal history to determine prior vaccination status. If the patient is uncertain about their vaccination history in the past five years, the vaccine should be given. However, if the

patient is certain he/she was vaccinated in the last five years, the vaccine should not be given. If the patient is certain that the vaccine was given and that more than five years have passed since receipt of the previous dose, revaccination is not appropriate unless the patient is at highest risk.

10.1.2 - Influenza Virus Vaccine

(Rev. 1, 10-01-03)

Effective for services furnished on or after May 1, 1993, the influenza virus vaccine and its administration is covered when furnished in compliance with any applicable State law. Typically, this vaccine is administered once a year in the fall or winter. Medicare does not require for coverage purposes that a doctor of medicine or osteopathy order the vaccine. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

Typically, one influenza vaccination is allowable per flu season. Contractors edit to identify more than one influenza virus vaccine in a 12-month period, and determine medical necessity of services failing the edit. Since there is no yearly limit, contractors determine whether such services are reasonable and necessary (e.g., a patient receives an influenza injection in January for the current flu season and is vaccinated again in November of the same year for the next flu season) and allow payment if appropriate.

See the Medicare Benefit Policy Manual, Chapter 15, for additional coverage requirements for Influenza Virus vaccines.

10.1.3 - Hepatitis B Vaccine

(Rev. 1, 10-01-03)

Effective for services furnished on or after September 1, 1984, the hepatitis B vaccine and its administration is covered if it is ordered by a doctor of medicine or osteopathy and is available to Medicare beneficiaries who are at high or intermediate risk of contracting hepatitis B, e.g., exposed to hepatitis B.

See the Medicare Benefit Policy Manual, Chapter 15, for additional coverage requirements for hepatitis B vaccines to high risk and intermediate risk groups.

10.2 - Billing Requirements

(Rev. 681, Issued: 09-16-05; Effective: 01-01-06; Implementation: 01-03-06)

A Edits Not Applicable to PPV or Influenza Virus Vaccine Bills and Their Administration The CWF and shared systems bypass all Medicare Secondary Payer (MSP) utilization edits in Common Working File (CWF) on all claims when the only service provided is PPV or influenza virus vaccine and/or their administration. This waiver does not apply when other services (e.g., office visits) are billed on the same claim as PPV or influenza vaccinations. If the provider knows or has reason to believe

that a particular group health plan covers PPV or influenza virus vaccine and their administration, and all other MSP requirements for the Medicare beneficiary are met, the primary payer must be billed.

First claim development alerts from CWF are not generated for PPV or influenza virus vaccines. However, first claim development is performed if other services are submitted along with PPV or development is performed if other services are submitted along with PPV or influenza virus vaccines.

See the Medicare Secondary Payer Manual, Chapters 4 and 5, for responsibilities for MSP development where applicable.

B Intermediary (FI) Bills

Chapter 25 of this manual provides general billing instructions that must be followed for bills submitted to FIs.

The following "providers of services" may administer and bill the FI for these vaccines:

- Hospitals;
- Critical Access Hospitals (CAHs);
- Skilled Nursing Facilities (SNFs);
- Home Health Agencies (HHAs);
- Comprehensive Outpatient Rehabilitation Facilities (CORFs); and
- Indian Health Service (IHS)/Tribally owned and/or operated hospitals and hospital-based facilities.

Other billing entities that may bill the FI are:

- Independent Renal Dialysis Facilities (RDFs).

All providers bill the FI for hepatitis B on Form CMS-1450. Providers other than independent RHCs and freestanding FQHCs bill the FI for influenza and PPV on Form CMS-1450. (See §10.2.2.2 of this chapter for special instructions for independent RHCs and freestanding FQHCs and §10.2.4 of this chapter for hospice instruction.)

FIs instruct providers, other than independent RHCs and freestanding FQHCs, to bill for the vaccines and their administration on the same bill. Separate bills for vaccines and their administration are not required. The only exceptions to this rule occur when the vaccine is administered during the course of an otherwise covered home health visit since the vaccine or its administration is not included in the visit charge. (See §10.2.3 of this chapter).

C Carrier Claims

1 Billing for Additional Services

When a physician/supplier administers PPV, influenza virus, or hepatitis B vaccines without providing any other additional services during the visit, the provider may only bill for the vaccine and its administration. These services are always separately payable, whether or not other services are also provided during the same encounter. The physician/supplier may bill for additional reasonable and necessary services in addition to the administration of PPV, influenza virus, and/or hepatitis B vaccines.

2 Nonparticipating Physicians and Suppliers

Nonparticipating physicians and suppliers (including local health facilities) that do not accept assignment may collect payment from the beneficiary for the administration of the vaccines, but must submit an unassigned claim on the beneficiary's behalf. Effective for claims with dates of service on or after February 1, 2001, per §114 of the Benefits Improvement and Protection Act of 2000, all drugs and biologicals must be paid based on mandatory assignment. Therefore, regardless of whether the physician and supplier usually accept assignment, they must accept assignment for the vaccines, may not collect any fee up front, and must submit the claim for the beneficiary.

Entities, such as local health facilities, that have never submitted Medicare claims must obtain a provider identification number for Part B billing purposes.

3 Beneficiary Submitted Claims

Carriers process beneficiary-submitted claims under procedures that are applied in other situations in which unassigned claims (e.g., Form CMS-1490s) are received from beneficiaries. The carrier sends an enrollment application to the physician or supplier shown on the beneficiary's receipt. Carriers must assign a provider number upon receipt of the application. (See the Program Integrity Manual, Chapter 10 for detailed instructions).

4 Separate Claims for Vaccine and Their Administration

In situations in which the vaccine and the administration are furnished by two different entities, the entities should submit separate claims. For example, a supplier (e.g., a pharmacist) may bill separately for the vaccine, using the Healthcare Common Procedural Coding System (HCPCS) code for the vaccine, and the physician or supplier (e.g., a drugstore) who actually administers the vaccine may bill separately for the administration, using the HCPCS code for the administration. This procedure results in carriers receiving two claims, one for the vaccine and one for its administration.

For example, when billing for influenza vaccine administration only, billers should list only HCPCS code G0008 in block 24D of the Form CMS-1500. When billing for the influenza vaccine only, billers should list only HCPCS code 90658 in block 24D of the

Form CMS -1500. The same applies for PPV and hepatitis B billing using PPV and hepatitis B HCPCS codes.

10.2.1 - Healthcare Common Procedural Coding System (HCPCS) and Diagnosis Codes

(Rev. 525, Issued: 04-15-05, Effective/Implementation: N/A)

Vaccines and their administration are reported using separate codes. The following codes are for reporting the vaccines only.

HCPCS	Definition
90655	Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use;
90656	Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use;
90657	Influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular use;
90658	Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use;
90659	Influenza virus vaccine, whole virus, for intramuscular or jet injection use (Discontinued December 31, 2003);
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use;
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use;
90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use;
90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use;
90746	Hepatitis B vaccine, adult dosage, for intramuscular use; and
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use.

The following codes are for reporting administration of the vaccines only. The administration of the vaccines is billed using:

HCPCS	Definition
G0008	Administration of influenza virus vaccine;
G0009	Administration of pneumococcal vaccine; and
G0010	Administration of hepatitis B vaccine.

One of the following diagnosis codes must be reported as appropriate. If the sole purpose for the visit is to receive a vaccine or if a vaccine is the only service billed on a claim the applicable following diagnosis code may be used.

Diagnosis Code	Description
V03.82	PPV
V04.8*	Influenza
V04.81**	Influenza
V05.3	Hepatitis B.

*Effective for influenza virus claims with dates of service prior to October 1, 2003.

**Effective for influenza virus claims with dates of service October 1, 2003 and later.

If a diagnosis code for PPV, hepatitis B, or influenza virus vaccination is not reported on a claim and the carrier can determine that the claim is a PPV, hepatitis B, or influenza claim, the carrier may enter the proper diagnosis code and continue processing the claim. These claims should not be returned, rejected, or denied for lack of a diagnosis code by the carrier. Effective for dates of service on or after October 1, 2003, carriers may no longer enter the diagnosis on the claim. Carriers must follow current resolution processes for claims with missing diagnosis codes.

If the diagnosis code and the narrative description are correct, but the HCPCS code is incorrect, the carrier or intermediary may correct the HCPCS code and pay the claim. For example, if the reported diagnosis code is V04.8 (V04.81 if claim is October 1, 2003, and later) and the narrative description (if annotated on the claim) says "flu shot" but the HCPCS code is incorrect, contractors may change the HCPCS code and pay for the flu vaccine.

Claims for hepatitis B vaccinations must report the I.D. Number of referring physician. In addition, if a doctor of medicine or osteopathy does not order the influenza virus vaccine, the intermediary claims require UPIN code SLF000 to be reported.

10.2.2 - Bills Submitted to FIs

(Rev. 681, Issued: 09-16-05; Effective: 01-01-06; Implementation: 01-03-06)

The applicable types of bills acceptable when billing for influenza and PPV are 12X, 13X, 22X, 23X, 34X, 72X, 75X, 83X and 85X.

The following revenue codes are used for reporting vaccines and administration of the vaccines for all providers except RHCs and FQHCs. Independent and Provider Based RHCs and FQHCs follow §10.2.2.2 below when billing for influenza, PPV and hepatitis B vaccines.

Units and HCPCS codes are required with revenue code 0636:

Revenue Code	Description
0636	Pharmacy, Drugs requiring detailed coding (a)
0771	Preventive Care Services, Vaccine Administration

In addition, for the influenza virus vaccine, providers report condition code M1 in Form Locator (FLs) 24-30 when roster billing. See roster billing instructions in §10.3 of this chapter.

When vaccines are provided to inpatients of a hospital or SNF, they are covered under the vaccine benefit. However, the hospital bills the FI on bill type 12X using the discharge date of the hospital stay or the date benefits are exhausted. A SNF submits type of bill 22X for its Part A inpatients.

10.2.2.1 - FI Payment for Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines

(Rev. 634, Issued: 08-03-05; Effective: 01-01-06; Implementation: 01-03-06)

Payment for all of these vaccines is on a reasonable cost basis for hospitals, home health agencies (HHAs), skilled nursing facilities (SNFs), critical access hospitals (CAHs) and provider-based renal dialysis facilities (RDFs). Comprehensive outpatient rehabilitation facilities (CORFs) and freestanding RDFs are paid based on the lower of actual charge or 95 percent of the average wholesale price (AWP). Section 10.2.4 of this chapter contains information on payment of these vaccines when provided by RDFs or hospice.

10.2.2.2 - Special Instructions for Independent and Provider-Based Rural Health Clinics/Federally Qualified Health Center (RHCs/FQHCs)

(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

Independent and provider-based RHCs and FQHCs do not include charges for influenza and PPV on Form CMS-1450. Administration of these vaccines does not count as a visit when the only service involved is the administration of influenza and/or PPV vaccine(s). If there was another reason for the visit, the RHC/FQHC should bill for the visit without adding the cost of the influenza and PPV to the charge for the visit on the bill. FIs pay at the time of cost settlement and adjust interim rates to account for this additional cost if they determine that the payment is more than a negligible amount.

Payment for the hepatitis B vaccine is included in the all-inclusive rate. However, RHCs/FQHCs do not bill for a visit when the only service involved is the administration of the hepatitis B vaccine. As with other vaccines administered during an otherwise payable encounter, no line items specifically for this service are billed on the RHC/FQHC claims in addition to the encounter.

10.2.3 - Bills Submitted to Regional Home Health Intermediaries (RHHIs)

(Rev. 1, 10-01-03)

A3-3660.7.H

The following provides billing instructions for Home Health Agency (HHAs) in various situations:

- Where the sole purpose for an HHA visit is to administer a vaccine (influenza, PPV, or hepatitis B), Medicare will not pay for a skilled nursing visit by an HHA nurse under the HHA benefit. However, the vaccine and its administration are covered under the vaccine benefit. The administration should include charges only for the supplies being used and the cost of the injection. RHHIs do not allow HHAs to charge for travel time or other expenses (e.g., gasoline). In this situation, the HHA bills under bill type 34X and reports revenue code 0636 along with the appropriate HCPCS code for the vaccine and revenue code 0771 along with the appropriate HCPCS code for the administration.

  NOTE: A separate bill is not allowed for the visit

- If a vaccine (influenza, PPV, or hepatitis B) is administered during the course of an otherwise covered home health visit (e.g., to perform wound care), the visit would be covered as normal but the HHA must not include the vaccine or its administration in their visit charge. In this case, the HHA is entitled to payment for the vaccine and its administration under the vaccine benefit. In this situation, the HHA bills under bill type 34X and reports revenue code 0636 along with the appropriate HCPCS code for the vaccine and revenue code 0771 along with the appropriate HCPCS code for the administration.

  NOTE: A separate bill is required for the visit

- Where a beneficiary does **not** meet the eligibility criteria for home health coverage, a home health nurse may be paid for the vaccine (influenza, PPV, or hepatitis B) and its administration. No skilled nursing visit charge is billable. Administration of the services should include charges only for the supplies being used and the cost of the injection. RHHIs do not pay for travel time or other expenses (e.g., gasoline). In this situation, the HHA bills under bill type 34X and reports revenue code 0636 along with the appropriate HCPCS code for the vaccine and revenue code 0771 along with the appropriate HCPCS code for the administration.

If a beneficiary meets the eligibility criteria for coverage, but his or her spouse does not, and the spouse wants an injection the same time as a nursing visit, HHAs bill in accordance with the bullet point above.

10.2.4 - Bills Submitted by Hospices and Payment Procedures for Renal Dialysis Facilities (RDF)

(Rev. 634, Issued: 08-03-05; Effective: 01-01-06; Implementation: 01-03-06)

Hospices can provide the influenza virus, PPV, and hepatitis B vaccines to those beneficiaries who request them including those who have elected the hospice benefit. These services may be covered when furnished by the hospice. Services for the vaccines should be billed to the local carrier on the Form CMS-1500. Payment is made using the same methodology as if they were a supplier. Hospices that do not have a supplier number should contact their local carrier to obtain one in order to bill for these benefits.

FIs pay for PPV, influenza, and Hepatitis B virus vaccines for freestanding Renal Dialysis facilities (RDFs) based on the lower of the actual charge or 95 percent of the average wholesale price (AWP) and based on reasonable cost for provider-based RDFs. Deductible and coinsurance do not apply for influenza and PPV vaccines. FIs must contact their carrier to obtain information in order to make payment for the administration of these vaccines.

Deductible and coinsurance apply for Hepatitis B vaccine.

10.2.4.1 - Hepatitis B Vaccine Furnished to ESRD Patients

(Rev. 1, 10-01-03)

PRM 1 2711.4

Hepatitis B vaccine and its administration (including staff time and supplies such as syringes) are paid to ESRD facilities in addition to, and separately from, the dialysis composite rate payment.

Payment for the hepatitis B vaccine for ESRD patients follows the same general principles that are applicable to any injectable drug or biological. Hospital-based

facilities are paid for their direct and indirect costs on a reasonable cost basis, and independent facilities are paid the lower of the actual charge or 95 percent of the AWP. The allowance for injectables is based on the cost of the injectable and any supplies used for administration, plus a maximum $2 for the labor involved, if the facility's staff administers the vaccine. In addition, the FI makes an appropriate allowance for facility overhead.

Where the vaccine is administered in a hospital outpatient department for home dialysis patients or for patients with chronic renal failure (but not yet on dialysis), payment is on a reasonable cost basis. Outpatient hospital vaccines for nondialysis purposes are paid under hospital outpatient PPS rules.

10.2.5 - Claims Submitted to Carriers

(Rev. 1, 10-01-03)

B3-4480.10

Physicians and suppliers submit claims on Form CMS -1500. The Unique Physician Identification Number (UPIN) (or National Provider Identifier (NPI), when effective) must be entered in Item 17A of Form CMS-1500 for PPV (prior to July 1, 2000) and hepatitis B vaccines. Medicare does not require that the influenza vaccine be administered under a physician's order or supervision. Effective for claims with dates of service on or after July 1, 2000, PPV claims also no longer require that the vaccine be administered under a physician's order or supervision.

A. Reporting Specialty Code/Place of Service (POS) to CWF

Specialty

Carriers use specialty code 60 (Public Health or Welfare Agencies (Federal, State, and Local)) for Public Health Service Clinics.

Carriers use specialty code 87 for pharmacists (all other suppliers (drug stores, department stores)).

Entities and individuals other than PHCs and pharmacists use the CMS specialty code that best defines their provider type. A list of specialty codes can be found in Chapter 26. The CMS specialty code 99 (Unknown Physician Specialty) is acceptable where no other code fits.

Place of Service (POS)

State or local PHCs use POS code 71 (State or Local Public Health Clinic). POS 71 is not used for individual offices/entities other than PHCs (e.g., a mobile unit that is non-PHC affiliated should use POS 99). Preprinted Form CMS-1500s used for simplified roster billing should show POS 60 (Mass Immunization Center) regardless of the site where vaccines are given (e.g., a PHC or physician's office that roster claims should use

POS 60). Individuals/entities administering influenza and PPV vaccinations in a mass immunization setting, regardless of the site where vaccines are given, should use POS 60 for roster claims, paper claims, and electronically filed claims.

Normal POS codes should be used in other situations.

Providers use POS 99 (Other Unlisted Facility) if no other POS code applies.

10.2.5.1 - Carrier Indicators for the Common Working File (CWF)

(Rev. 1, 10-01-03)

The carrier record submitted to the common working file (CWF) must contain the following indicators:

Description	Payment Indicator	Payment	Deductible Indicator	Deductible	Type of Service
PPV	"1"	100 percent	"1"	Zero deductible	"V"
Influenza	"1"	100 percent	"1"	Zero deductible	"V"
Hepatitis B	"0"	80 percent	"0"	Deductible applies	"1"

A payment indicator of "1" represents 100 percent payment. A deductible indicator of "1" represents a zero deductible. A payment indicator of "0" represents 80 percent payment. A deductible indicator of "0" indicates that a deductible applies to the claim.

The record must also contain a "V" in the type of service field, which indicates that this is a PPV or influenza virus vaccine. Carriers use a "1" in the type of service field which indicates medical care for a hepatitis B vaccine.

10.2.5.2 - Carrier Payment Requirements

(Rev. 525, Issued: 04-15-05, Effective/Implementation: N/A)

Payment for PPV, influenza virus, and hepatitis B vaccines follows the same standard rules that are applicable to any injectable drug or biological. (See Chapter 17 for procedures for determining the payment rates for PPV and Influenza virus vaccines.)

Effective for claims with dates of service on or after February 1, 2001, §114, of the Benefits Improvement and Protection Act of 2000 mandated that all drugs and biologicals be paid based on mandatory assignment. Therefore, all providers of flu and PPV vaccines must accept assignment for the vaccine.

The administration of PPV, influenza virus, and hepatitis B vaccines, (HCPCS codes G0009, G0008, and G0010), though not reimbursed directly through the MPFS, is reimbursed at the same rate as HCPCS code 90782 on the MPFS for the year that corresponds to the date of service of the claim.

Beginning March 1, 2003, HCPCS codes G0008, G0009, and G0010 should be reimbursed at the same rate as HCPCS code 90471. Assignment for the administration is not mandatory, but is applicable should the provider be enrolled as a provider type "Mass Immunizer," submits roster bills, or participates in the centralized billing program.

Carriers may not apply the limiting charge provision for PPV, influenza virus vaccine, or hepatitis B vaccine and their administration in accordance with §§1833(a)(1) and 1833(a)(10)(A) of the Social Security Act (the Act.) The administration of the influenza virus vaccine is covered in the flu vaccine benefit under §1861(s)(10)(A) of the Act, rather than under the physicians' services benefit. Therefore, it is not eligible for the 10 percent Health Professional Shortage Area (HPSA) incentive payment.

A. No Legal Obligation to Pay

Nongovernmental entities that provide immunizations free of charge to all patients, regardless of their ability to pay, must provide the immunizations free of charge to Medicare beneficiaries and may not bill Medicare. (See the Medicare Benefit Policy Manual, Chapter 16.) Thus, for example, Medicare may not pay for flu vaccinations administered to Medicare beneficiaries if a physician provides free vaccinations to all non-Medicare patients or where an employer offers free vaccinations to its employees. Physicians also may not charge Medicare beneficiaries more for a vaccine than they would charge non-Medicare patients. (See §1128 (b)(6)(A) of the Act.)

Nongovernmental entities that do not charge patients who are unable to pay or reduce their charges for patients of limited means, yet expect to be paid if the patient has health insurance coverage for the services provided, may bill Medicare and expect payment.

Governmental entities (such as public health clinics (PHCs)) may bill Medicare for PPV, hepatitis B, and influenza virus vaccine administered to Medicare beneficiaries when services are rendered free of charge to non-Medicare beneficiaries.

10.3 - Simplified Roster Claims for Mass Immunizers

(Rev. 1, 10-01-03)

B3-4480.8, A3-3660.7, SNF-534.F, G, HSP-303.6.D, HO-435.G, H, HHA-473.H, I, B3-3001.1 (partial) SNF-536.2.F, B3-4480.9, B3-4481

The simplified roster billing process was developed to enable Medicare beneficiaries to participate in mass PPV and influenza virus vaccination programs offered by Public Health Clinics (PHCs) and other individuals and entities that give the vaccine to a group of beneficiaries, e.g. at public health clinics, shopping malls, grocery stores, senior citizen homes, and health fairs. Roster billing is not available for hepatitis B vaccinations.

Properly licensed individuals and entities conducting mass immunization programs may submit claims using a simplified claims filing procedure known as roster billing to bill for the influenza virus vaccine benefit for multiple beneficiaries if they agree to accept assignment for these claims. They may not collect any payment from the beneficiary. Effective November 1, 1996, roster billing is also available to individuals and entities billing for PPV.

Effective July 1, 1998, immunization of at least five beneficiaries on the same date is no longer required for any individual or entity to qualify for roster billing to carriers. However, the rosters should not be used for single patient claims and the date of service for each vaccination administered must be entered.

Entities that submit claims on roster claims must accept assignment and may not collect any "donation" or other cost sharing of any kind from Medicare beneficiaries for PPV or influenza vaccinations. However, the entity may bill Medicare for the amount, which is not subsidized from its own budget. For example, an entity that incurs a cost of $7.50 per vaccination and pays $2.50 of the cost from its budget may bill Medicare the $5.00 cost which is not paid out of its budget.

A. Provider Enrollment Criteria for Mass Immunizers

B3-4480.8.A

Those entities and individuals that desire to provide mass immunization services, but may not otherwise be able to qualify as a Medicare provider, may be eligible to enroll as a provider type "Mass Immunizer."

These individuals and entities must enroll with the carrier by completing the Provider/Supplier Enrollment Application, Form CMS-855. Specialized instructions for these individuals and entities are available in order to simplify the enrollment process. Individuals and entities that use the specialized instructions to complete the form may not bill Medicare for any services other than PPV, influenza virus vaccines and their administration.

Carriers must establish an edit to identify "Mass Immunizers" that plan to participate in the Medicare program only for the purpose of mass immunizing beneficiaries. In addition, carriers must edit to allow only the provider type "Mass Immunizer" to be reimbursed at the assigned payment rate.

B. Payment Floor for Roster Claims

B3-4480.8.C

Roster claims are considered paper claims and are not paid as quickly as electronic media claims (EMC). If available, offer electronic billing software free or at-cost to PHCs and other properly licensed individuals and entities. Carriers must ensure that the software is as user friendly as possible for the PPV and influenza virus vaccine benefits.

C. Managed Care + Choice Organization (M+CO) Processing Requirements

B3-4480.9

M+C organizations may use roster billing only if vaccinations are the only Medicare-covered services furnished by the M+CO to Medicare patients who are not members of the M+CO. M+COs must use Place of Service (POS) code 60 for processing roster claims.

10.3.1 - Roster Claims Submitted to Carriers for Mass Immunization

(Rev. 525, Issued: 04-15-05, Effective/Implementation: N/A)

If the PHC or other individual or entity qualifies to submit roster claims, it may use a preprinted Form CMS-1500 that contains standardized information about the entity and the benefit. Key information from the beneficiary roster list and the abbreviated Form CMS-1500 is used to process PPV and influenza virus vaccination claims.

Separate Form CMS-1500 claim forms, along with separate roster bills, must be submitted for PPV and influenza roster billing.

If other services are furnished to a beneficiary along with PPV or influenza virus vaccine, individuals and entities must submit claims using normal billing procedures, e.g., submission of a Form CMS-1500 or electronic billing for each beneficiary.

Providers submitting electronic roster bills must submit their claims in a National Standard Format (NSF) or the American National Standards Institute Accredited Standards Committee X12 837 Health Care Claim American National Standards Institute (ANSI) ASC X12N 837.

Carriers must create and count one claim per beneficiary from roster bills. They must split claims for each beneficiary if there are multiple beneficiaries included in a roster bill. Providers must show the unit cost for one service on the modified Form CMS-1500. The carrier must replicate the claim for each beneficiary listed on the roster.

Carriers must provide Palmetto-Railroad Retirement Board (RRB) with local pricing files for PPV and influenza vaccine and their administration. They must replicate the roster and the Form CMS-1500, highlighting the RRB beneficiary on the roster, and forward the material to the appropriate Palmetto-RRB processing center.

If PHCs or other individuals or entities inappropriately bill PPV or influenza vaccination using the roster billing method, carriers return the claim to the provider with a cover letter explaining why it is being returned and the criteria for the roster billing process. Carriers may not deny these claims.

Providers must retain roster bills with beneficiaries' signatures at their permanent location for a time period consistent with Medicare regulations.

A. Modified Form CMS-1500 for Cover Document

Entities submitting roster claims to carriers must complete the following blocks on a single modified Form CMS-1500, which serves as the cover document for the roster for each facility where services are furnished. In order for carriers to reimburse by correct payment locality, a separate Form CMS-1500 must be used for each different facility where services are furnished.

Item 1: An X in the Medicare block

Item 2: (Patient's Name): "SEE ATTACHED ROSTER"

Item 11: (Insured's Policy Group or FECA Number): "NONE"

Item 20: (Outside Lab?): An "X" in the NO block

Item 21: (Diagnosis or Nature of Illness):

Line 1: PPV = "V03.82", Influenza Virus: = "V04.8"

Effective for claims with dates of service on or after October 1, 2003, use V04.81.

Item 24B: (Place of Service (POS)):

Line 1: "60"

Line 2: "60"

NOTE: POS Code '60" must be used for roster billing.

Item 24D: (Procedures, Services or Supplies):

Line 1:

PPV: "90732"

Influenza Virus: "90658"

Line 2:

PPV: "G0009"

Influenza Virus: "G0008"

Item 24E: (Diagnosis Code):

Lines 1 and 2: "1"

Item 24F: ($ Charges): The entity must enter the charge for each listed service. If the entity is not charging for the vaccine or its administration, it should enter 0.00 or "NC" (no charge) on the appropriate line for that item. If your system is unable to accept a line item charge of 0.00 for an immunization service, do not key the line item. Likewise, electronic media claim (EMC) billers should submit line items for free immunization services on EMC PPV or influenza virus vaccine claims only if your system is able to accept them.

Item 27: (Accept Assignment): An "X" in the YES block.

Item 29: (Amount Paid): "$0.00"

Item 31: (Signature of Physician or Supplier): The entity's representative must sign the modified Form CMS-1500.

Item 33: (Physician's, Supplier's Billing Name): If the provider number is not shown on the roster billing form, the entity must complete this item to include the Provider Identification Number (not the Unique Physician Identification Number) or Group Number, as appropriate.

B. Format of Roster Claims

Qualifying individuals and entities must attach to the Form CMS-1500 claims form, a roster which contains the variable claims information regarding the supplier of the service and individual beneficiaries. While qualifying entities must use the modified Form CMS-1500 without deviation, carriers must work with these entities to develop a mutually suitable roster that contains the minimum data necessary to satisfy claims processing requirements for these claims. Carriers must key information from the beneficiary roster list and abbreviated Form CMS-1500 to process PPV and influenza virus vaccination claims.

The roster must contain at a minimum the following information:

- Provider name and number;
- Date of service;

  NOTE: Although physicians who provide PPV or influenza virus vaccinations may roster bill if they vaccinate fewer than five beneficiaries per day, they must include the individual date of service for each beneficiary's vaccination on the roster form.

- Control number for contractor;
- Patient's health insurance claim number;
- Patient's name;

- Patient's address;
- Date of birth;
- Patient's sex; and
- Beneficiary's signature or stamped "signature on file.

NOTE: A stamped "signature on file" qualifies as an actual signature on a roster claim form if the provider has a signed authorization on file to bill Medicare for services rendered. In this situation, the provider is not required to obtain the patient signature on the roster, but instead has the option of reporting signature on file in lieu of obtaining the patient's actual signature.

The PPV roster must contain the following language to be used by providers as a precaution to alert beneficiaries prior to administering PPV.

WARNING: Beneficiaries must be asked if they have been vaccinated with a PPV.

- Rely on patients' memory to determine prior vaccination status.
- If patients are uncertain whether they have been vaccinated within the past 5 years, administer the vaccine.
- If patients are certain that they have been vaccinated within the past 5 years, **do not revaccinate.**

10.3.1.1 - Centralized Billing for Flu and Pneumococcal (PPV) Vaccines to Medicare Carriers

(Rev. 525, Issued: 04-15-05, Effective/Implementation: N/A)

The CMS currently authorizes a limited number of providers to centrally bill for flu and PPV immunization claims. Centralized billing is an optional program available to providers who qualify to enroll with Medicare as the provider type “Mass Immunizer,” as well as to other individuals and entities that qualify to enroll as regular Medicare providers. Centralized billers must roster bill, must accept assignment, and must bill electronically.

To qualify for centralized billing, a mass immunizer must be operating in at least three payment localities for which there are three different carriers processing claims. Individuals and entities providing the vaccine and administration must be properly licensed in the State in which the immunizations are given and the carrier must verify this through the enrollment process.

Centralized billers must send all claims for flu and PPV immunizations to a single carrier for payment, regardless of the carrier jurisdiction in which the vaccination was administered. (This does not include claims for the Railroad Retirement Board, United

Mine Workers or Indian Health Services. These claims must continue to go to the appropriate processing entity.) Payment is made based on the payment locality where the service was provided. This process is only available for claims for the flu and PPV vaccines and their administration. The general coverage and coding rules still apply to these claims.

This section applies only to those individuals and entities that provide mass immunization services for flu and PPV vaccinations and that have been authorized by CMS to centrally bill. All other providers, including those individuals and entities that provide mass immunization services that are not authorized to centrally bill, must continue to bill for these claims to their regular carrier per the instructions in §10.3.1 of this chapter.

The claims processing instructions in this section apply only to the designated processing carrier. However, all carriers must follow the instructions in §10.3.1.1.J, below, "Provider Education Instructions for All Carriers."

A. Processing Carrier

TrailBlazer Health Enterprises is designated as the sole carrier for the payment of flu and PPV claims for centralized billers from October 1, 2000 through the length of the contract. The CMS central office (CO) will notify centralized billers of the appropriate carrier to bill when they receive their notification of acceptance into the centralized billing program.

B. Request for Approval

If an individual or entity's request is approved for centralized billing, the approval is limited to 12 months from September to August 31 of the next year. It is the responsibility of the centralized biller to reapply to CMS CO for approval each year by June 1. Carriers may not process claims for any centralized biller without prior permission from CMS CO. If claims are submitted by a provider that is not currently approved as a centralized biller, the carrier must return the claims to the provider to submit to the local carrier for payment.

C. Notification of Provider Participation to the Processing Carrier

Before October 1 of every year, CMS CO provides the designated carrier with the names of the entities that are authorized to participate in centralized billing for the 12 month period beginning October 1 and ending September 30 of the next year.

D. Enrollment

Though centralized billers may already have a Medicare provider number, for purposes of centralized billing, they must also obtain a provider number from the processing carrier for centralized billing through completion of the Form CMS-855 (Provider Enrollment Application).

Whether an entity enrolls as a provider type "Mass Immunizer" or some other type of provider, all normal enrollment processes and procedures must be followed. Authorization from CO to participate in centralized billing is dependent upon the entity's ability to qualify as some type of Medicare provider. In addition, as under normal enrollment procedures, the carrier must verify that the entity is fully qualified and certified per State requirements in each State in which they plan to operate.

The carrier will activate the provider number for the 12-month period from September 1 through August 31 of the following year. If the provider is authorized to participate in the centralized billing program the next year, the carrier will extend the activation of the provider number for another year. The entity need not re-enroll with the carrier every year. However, should the States in which the entity plans to operate change, the carrier will need to verify that the entity meets all State certification and licensure requirements in those new States.

E. Electronic Submission of Claims on Roster Bills

Centralized billers must agree to submit their claims on roster bills in an Electronic Media Claims standard format using either the National Standard Format (NSF) or American National Standards Institute ANSI X12N 837 format (or the HIPAA ANSI X12N 837(version 4010) when required). The processing carrier must provide instructions on acceptable roster billing formats to the approved centralized billers. Paper claims will not be accepted.

F. Required Information on Roster Bills for Centralized Billing

In addition to the roster billing instructions found in §10.3.1 of this chapter, centralized billers must complete on the electronic format the area that corresponds to Item 32, (Name and Address of Facility, including ZIP code) on Form CMS-1500. The carrier must use the ZIP code in this field to determine the payment locality for the claim.

For electronic claims, the name and address of the facility is reported in:

- The National Standard Format, record EA0, field 39 (facility/lab name) and record EA1, fields 6 through 10 (facility/lab address, city, state and ZIP code);

- The ANSI X12N 837 (version (3051): Claim level loop 2310, 2-250-NM1, with a value of "61" (Performed at the Facility where work was performed) in NM101, a value of "FA" (Facility ID) or "ZZ" (NPI - when implemented) in NM108, and the Provider Number in NM109. Report the address in N3 and N4; or

- The HIPAA ANSI X12N 837(version 4010): Claim level loop 2310D, 2-250-NM1, with a qualifier value of "FA" (Facility) in NM101, a value of "XX" (NPI) - when implemented) in NM108, and the Provider Number ID in NM109. Prior to NPI, enter the Provider Number in loop 2310D position 2-271-REF using "1C" (Medicare Provider Number) in REF01 and the facility ID in REF02. Report the address in N3 and N4.

G. Payment Rates and Mandatory Assignment

The payment rates for the administration of the vaccinations are based on the Medicare Physician Fee Schedule (MPFS) for the appropriate year. Payment made through the MPFS is based on geographic locality. Therefore, payments vary based on the geographic locality where the service was performed.

The HCPCS codes G0008 and G0009 for the administration of the vaccines are not paid on the MPFS. However, they must be paid at the same rate as HCPCS code 90782, which is on the MPFS. The designated carrier must pay per the correct MPFS file for each calendar year based on the date of service of the claim. Beginning March 1, 2003, HCPCS codes G0008, G0009, and G0010 are to be reimbursed at the same rate as HCPCS code 90471.

In order to pay claims correctly for centralized billers, the designated carrier must have the correct name and address, including ZIP code, of the entity where the service was provided. If a claim is received with a ZIP code that is not included on the ZIP code file maintained by designated carrier, they should refer to the United State Postal Service (USPS) Web site at http://www.usps.com/ncsc/ziplookup/lookupmenu.htm to determine if the ZIP code presented is valid. If the ZIP code is valid, they should add it to the designated carrier maintained ZIP code file and pay the claim using the appropriate payment locality.

If a claim is received with a ZIP code that is not valid for the street address given and the designated carrier can determine the correct ZIP code from the USPS Web site, the designated carrier must correct the ZIP code on the claim and pay the claim using the appropriate payment locality.

If the ZIP code presented is not a valid ZIP code, or is not a valid ZIP code with the given street address and the correct ZIP code cannot be determined from the USPS Web site, the designated carrier must deny the claim.

The following remittance advice and Medicare Summary Notice (MSN) messages apply:

> Claim adjustment reason code 16, “Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.” in addition to remittance advice remark code MA114, “Missing/incomplete/invalid information on where the services were furnished.”
>
> MSN 9.4 - “This item or service was denied because information required to make payment was incorrect.”

The payment rates for the vaccines must be determined by the standard method used by Medicare for reimbursement of drugs and biologicals. (See chapter 17 for procedures for determining the payment rates for vaccines.)

Effective for claims with dates of service on or after February 1, 2001, §114, of the Benefits Improvement and Protection Act of 2000 mandated that all drugs and biologicals be paid based on mandatory assignment. Therefore, all providers of flu and PPV vaccines must accept assignment for the vaccine. In addition, as a requirement for both centralized billing and roster billing, providers must agree to accept assignment for the administration of the vaccines as well. This means that they must agree to accept the amount that Medicare pays for the vaccine and the administration. Also, since there is no coinsurance or deductible for the flu and PPV benefit, accepting assignment means that Medicare beneficiaries cannot be charged for the vaccination.

H. Common Working File Information

To identify these claims and to enable central office data collection on the project, special processing number 39 has been assigned. The number should be entered on the HUBC claim record to CWF in the field titled Demonstration Number.

I. Provider Education Instructions for the Processing Carrier

The processing carrier must fully educate the centralized billers on the processes for centralized billing as well as for roster billing. General information on flu and PPV coverage and billing instructions is available on the CMS Web site for providers.

J. Provider Education Instructions for All Carriers

By April 1 of every year, all carriers must publish in their bulletins and put on their Web sites the following notification to providers. Questions from interested providers should be forwarded to the central office address below. Carriers must enter the name of the assigned processing carrier where noted before sending.

NOTIFICATION TO PROVIDERS

> Centralized billing is a process in which a provider, who provides mass immunization services for influenza and Pneumococcal (PPV) immunizations, can send all claims to a single carrier for payment regardless of the geographic locality in which the vaccination was administered. (This does not include claims for the Railroad Retirement Board, United Mine Workers or Indian Health Services. These claims must continue to go to the appropriate processing entity.) This process is only available for claims for the flu and PPV vaccines and their administration. The administration of the vaccinations is reimbursed at the assigned rate based on the Medicare physician fee schedule for the appropriate locality. The vaccines are reimbursed at the assigned rate using the Medicare standard method for reimbursement of drugs and biologicals.
>
> Individuals and entities interested in centralized billing must contact CMS central office (CO), in writing, at the following address by June 1 of the year they wish to begin centrally billing.
>
> Center for Medicare & Medicaid Services

Division of Practitioner Claims Processing
Provider Billing and Education Group
7500 Security Boulevard
Mail Stop C4-12-18
Baltimore, Maryland 21244

By agreeing to participate in the centralized billing program, providers agree to abide by the following criteria.

CRITERIA FOR CENTRALIZED BILLING

- To qualify for centralized billing, an individual or entity providing mass immunization services for flu and pneumonia must provide these services in at least three payment localities for which there are at least three different carriers processing claims.

- Individuals and entities providing the vaccine and administration must be properly licensed in the State in which the immunizations are given.

- Centralized billers must agree to accept assignment (i.e., they must agree to accept the amount that Medicare pays for the vaccine and the administration). Since there is no coinsurance or deductible for the flu and PPV benefit, accepting assignment means that Medicare beneficiaries cannot be charged for the vaccination, i.e., beneficiaries may not incur any out-of-pocket expense. For example, a drugstore may not charge a Medicare beneficiary $10 for an influenza vaccination and give the beneficiary a coupon for $10 to be used in the drugstore. This practice is unacceptable.

- The carrier assigned to process the claims for centralized billing is chosen at the discretion of CMS based on such considerations as workload, user-friendly software developed by the contractor for billing claims, and overall performance. The assigned carrier for this year is [Fill in name of carrier.]

- The payment rates for the administration of the vaccinations are based on the Medicare physician fee schedule (MPFS) for the appropriate year. Payment made through the MPFS is based on geographic locality. Therefore, payments received may vary based on the geographic locality where the service was performed. Payment is made at the assigned rate.

- The payment rates for the vaccines are determined by the standard method used by Medicare for reimbursement of drugs and biologicals. Payment is made at the assigned rate.

- Centralized billers must submit their claims on roster bills in an approved Electronic Media Claims standard format. Paper claims will not be accepted.

- Centralized billers must obtain certain information for each beneficiary including name, health insurance number, date of birth, sex, and signature. [Fill in name of carrier] must be contacted prior to the season for exact requirements. The responsibility lies with the centralized biller to submit correct beneficiary Medicare information (including the beneficiary's Medicare Health Insurance Claim Number) as the carrier will not be able to process incomplete or incorrect claims.

- Centralized billers must obtain an address for each beneficiary so that a Medicare Summary Notice (MSN) can be sent to the beneficiary by the carrier. Beneficiaries are sometimes confused when they receive an MSN from a carrier other than the carrier that normally processes their claims which results in unnecessary beneficiary inquiries to the Medicare carrier. Therefore, centralized billers must provide every beneficiary receiving an influenza or PPV vaccination with the name of the processing carrier. This notification must be in writing, in the form of a brochure or handout, and must be provided to each beneficiary at the time he or she receives the vaccination.

- Centralized billers must retain roster bills with beneficiary signatures at their permanent location for a time period consistent with Medicare regulations. [Fill in name of carrier] can provide this information.

- Though centralized billers may already have a Medicare provider number, for purposes of centralized billing, they must also obtain a provider number from [Fill in name of carrier]. This can be done by completing the Form CMS-855 (Provider Enrollment Application), which can be obtained from [Fill in name of carrier].

- If an individual or entity's request for centralized billing is approved, the approval is limited to the 12 month period from September 1 through August 31 of the following year. It is the responsibility of the centralized biller to reapply to CMS CO for approval each year by June 1. [Fill in name of carrier] will not process claims for any centralized biller without permission from CMS CO.

- Each year the centralized biller must contact [Fill in name of carrier] to verify understanding of the coverage policy for the

administration of the PPV vaccine, and for a copy of the warning language that is required on the roster bill.

- The centralized biller is responsible for providing the beneficiary with a record of the PPV vaccination.

  The information in items 1 through 6 below must be included with the individual or entity's annual request to participate in centralized billing:

  1. Estimates for the number of beneficiaries who will receive influenza virus vaccinations;

  2. Estimates for the number of beneficiaries who will receive PPV vaccinations;

  3. The approximate dates for when the vaccinations will be given;

  4. A list of the States in which flu and PPV clinics will be held;

  5. The type of services generally provided by the corporation (e.g., ambulance, home health, or visiting nurse); and

  6. Whether the nurses who will administer the flu and PPV vaccinations are employees of the corporation or will be hired by the corporation specifically for the purpose of administering flu and PPV vaccinations.

10.3.2 - Claims Submitted to FIs for Mass Immunizations of Influenza and PPV

(Rev. 542, Issued: 04-29-05; Effective: 10-01-05; Implementation: 10-03-05)

Some potential "mass immunizers," such as hospital outpatient departments and HHAs, have expressed concern about the complexity of billing for the influenza virus vaccine and its administration. Consequently, to increase the number of beneficiaries who obtain needed preventive immunizations, simplified (roster) billing procedures are available to mass immunizers. The simplified (roster) claims filing procedure has been expanded for PPV. A mass immunizer is defined as any entity that gives the influenza virus vaccine or PPV to a group of beneficiaries, e.g., at public health clinics, shopping malls, grocery stores, senior citizen homes, and health fairs. To qualify for roster billing, immunizations of at least five beneficiaries on the same date are required. (See §10.3.2.2 for an exception to this requirement for inpatient hospitals.)

The simplified (roster) claims filing procedure applies to providers other than RHCs and FQHCs that conduct mass immunizations. Since independent and provider based RHCs

and FQHCs do not submit individual Form CMS-1450s for the influenza virus vaccine, they do not utilize the simplified billing process. Instead, payment is made for the vaccine at the time of cost settlement.

The simplified process involves use of the provider billing form (Form CMS-1450) with preprinted standardized information relative to the provider and the benefit. Mass immunizers attach a standard roster to a single pre-printed Form CMS-1450 that contains the variable claims information regarding the service provider and individual beneficiaries.

Qualifying individuals and entities must attach a roster, which contains the variable claims information regarding the supplier of the service and individual beneficiaries.

The roster must contain at a minimum the following information:

- Provider name and number;
- Date of service;
- Patient name and address;
- Patient date of birth;
- Patient sex;
- Patient health insurance claim number; and
- Beneficiary signature or stamped "signature on file."

In addition, for inpatient Part B services (12x and 22X) the following data elements are also needed:

- Admission date;
- Admission type;
- Admission diagnosis;
- Admission source code;
- Patient status code; and
- Discharge date.

NOTE: A stamped "signature on file" can be used in place of the beneficiary's actual signature for all institutional providers that roster bill from an inpatient or outpatient department provided the provider has a signed authorization on file to bill Medicare for services rendered. In this situation, they are not required to obtain the patient signature

on the roster. However, the provider has the option of reporting "signature on file" in lieu of obtaining the patient's actual signature on the roster.

The PPV roster must contain the following language to be used by providers as a precaution to alert beneficiaries prior to administering PPV.

Warning: Beneficiaries must be asked if they have been vaccinated with PPV.

- Rely on the patients' memory to determine prior vaccination status.
- If patients are uncertain whether they have been vaccinated within the past 5 years, administer the vaccine,
- If patients are certain that they have been vaccinated within the past 5 years, **do not revaccinate**.

For providers using the simplified billing procedure, the modified Form CMS-1450 shows the following preprinted information in the specific form locators (FLs):

- The words "See Attached Roster" in FL 12, (Patient Name);
- Patient Status code 01 in FL 22 (Patient Status);
- Condition code M1 in FLs 24-30 (Condition Code) (See NOTE below);
- Condition code A6 in FLs 24-30 (Condition Code);
- Revenue code 636 in FL 42 (Revenue Code), along with the appropriate HCPCS code in FL 44 (HCPCS Code);
- Revenue code 771 in FL 42 (Revenue Code), along with the appropriate "G" HCPCS code in FL 44 (HCPCS Code);
- "Medicare" on line A of FL 50 (Payer);
- The words "See Attached Roster" on line A of FL 51 (Provider Number); and
- Diagnosis code V03.82 for PPV or V04.8 for Influenza Virus vaccine in FL 67 (Principal Diagnosis Code). For influenza virus vaccine claims with dates of service October 1, 2003 and later, use diagnosis code V04.81.
- Influenza virus vaccines require the UPIN SLF000 in FL 82.

Providers conducting mass immunizations are required to complete the following FLs on the preprinted Form CMS-1450:

- FL 4 (Type of Bill);
- FL 47 (Total Charges);

- FL 85 (Provider Representative); and

- FL 86 (Date).

NOTE: Medicare Secondary Payer (MSP) utilization editing is bypassed in CWF for all mass immunizer roster bills. However, if the provider knows that a particular group health plan covers the PPV and all other MSP requirements for the Medicare beneficiary are met, the primary payer must be billed. First claim development alerts from CWF are not generated for PPV and influenza virus vaccines.

Intermediaries use the beneficiary roster list to generate Form CMS-1450s to process PPV claims by mass immunizers indicating condition code M1 in FLs 24-30 to avoid MSP editing. Standard System Maintainers must develop the necessary software to generate Form CMS-1450 records that will process through their system.

Providers that do not mass immunize must continue to bill for PPV and influenza virus vaccines using the normal billing method, e.g., submission of a Form CMS-1450 or electronic billing for each beneficiary.

10.3.2.1 - Simplified Billing for Influenza Virus Vaccine and PPV Services by HHAs

(Rev. 1, 10-01-03)

A3-3660.7.M

The following billing instructions apply to HHAs that roster bill for influenza virus and PPV vaccines.

- When a HHA provides the influenza virus vaccine or PPV in a mass immunization setting, it does not have the option to pick and choose whom to bill for this service. If it is using employees from the certified portion, and as a result will be reflecting these costs on the cost report, it must bill the FI on the Form CMS-1450.

- If the HHA is using employees from the noncertified portion of the agency (employees of another entity that are not certified as part of the HHA), and as a result, will not be reflecting these costs on the cost report, it must obtain a provider number and bill their carrier on the Form CMS-1500.

- If employees from both certified and noncertified portions of the HHA furnish the vaccines at a single mass immunization site, they must prepare two separate rosters, e.g., one for employees of the certified portion to be submitted to the FI and one roster for employees of the noncertified portion to be submitted to the carrier

10.3.2.2 - Hospital Inpatient Roster Billing

(Rev. 1, 10-01-03)

A3-3660.7.M

The following billing instructions apply to hospitals that roster bill for the influenza virus vaccine and PPV provided to inpatients:

- Hospitals do not have to wait until patients are discharged to provide the vaccine. They may provide it anytime during the patient's stay;
- The roster should reflect the actual date of service;
- The requirement to provide the vaccine to five or more patients at the same time to meet the requirements for mass immunizers is waived when vaccines are provided to hospital inpatients. Therefore, the roster may contain fewer than five patients or fewer than five patients on the same day; and
- The roster should contain information indicating that the vaccines were provided to inpatients to avoid questions regarding the number of patients or various dates.

10.3.2.3 - Electronic Roster Claims

(Rev. 1, 10-01-03)

A3-3660.7.N

As for all other Medicare-covered services, FIs pay electronic claims more quickly than paper claims. For payment floor purposes, roster bills are paper bills and may not be paid as quickly as EMC. (See Chapter 1.) If available, FIs must offer free, or at-cost, electronic billing software and ensure that the software is as user friendly as possible for the influenza virus vaccine benefit.

10.4 - CWF Edits

(Rev. 525, Issued: 04-15-05, Effective/Implementation: N/A)

In order to prevent duplicate payments for flu and pneumonia claims by the same FI or carrier and by local carriers and the centralized billing flu and pneumonia carrier, effective for claims received on or after July 1, 2002, CWF has implemented a number of edits.

NOTE: 90659 was discontinued December 31, 2003.

CWF returns information in Trailer 13 information from the history claim. The following fields are returned to the contractor:

- Trailer Code;

- Contractor Number;
- Document Control Number;
- First Service Date;
- Last Service Date;
- Provider, Physician, Supplier Number;
- Claim Type;
- Procedure code;
- Alert Code (where applicable); and,
- More history (where applicable.)

10.4.1 - CWF Edits on FI Claims

(Rev. 1, 10-01-03)

In order to prevent duplicate payment by the same FI, CWF edits by line item on the FI number, the beneficiary Health Insurance Claim (HIC) number, and the date of service, the flu procedure codes 90657, 90658, or 90659, the pneumonia procedure code 90732, and the administration codes G0008 or G0009.

If CWF receives a claim with either HCPCS codes 90657, 90658 or 90659, and it already has on record a claim with the same HIC number, same FI number, same date of service, and any one of those HCPCS codes, the second claim submitted to CWF rejects.

If CWF receives a claim with HCPCS code 90732 and it already has on record a claim with the same HIC number, same FI number, same date of service, and the same HCPCS code, the second claim submitted to CWF rejects when all four items match.

If CWF receives a claim with HCPCS administration codes G0008 or G0009 and it already has on record a claim with the same HIC number, same FI number, same date of service, and same procedure code, CWF rejects the second claim submitted when all four items match.

CWF returns to the FI a reject code “7262” for this edit. FIs must deny the second claim and use the same messages they currently use for the denial of duplicate claims.

10.4.2 - CWF Edits on Carrier Claims

(Rev. 525, Issued: 04-15-05, Effective/Implementation: N/A)

In order to prevent duplicate payment by the same carrier, CWF will edit by line item on the carrier number, the HIC number, the date of service, the flu procedure codes 90657, 90658, or 90659, the pneumonia procedure code 90732, and the administration code G0008 or G0009.

If CWF receives a claim with either HCPCS codes 90657, 90658 or 90659, and it already has on record a claim with the same HIC number, same carrier number, same date of service, and any one of those HCPCS codes, the second claim submitted to CWF will reject.

If CWF receives a claim with HCPCS code 90732 and it already has on record a claim with the same HIC number, same carrier number, same date of service, and the same HCPCS code, the second claim submitted to CWF will reject when all four items match.

If CWF receives a claim with HCPCS administration codes G0008 or G0009 and it already has on record a claim with the same HIC number, same carrier number, same date of service, and same procedure code, CWF will reject the second claim submitted.

CWF will return to the carriers a specific reject code for this edit that will be named in the CWF documentation. Carriers must deny the second claim and use the same messages they currently use for the denial of duplicate claims.

In order to prevent duplicate payment by the centralized billing carrier and local carrier, CWF will edit by line item for carrier number, same HIC number, same date of service, the flu procedure codes 90657, 90658, 90659, the pneumonia procedure code 90732, and the administration code G0008 or G0009.

If CWF receives a claim with either HCPCS codes 90657, 90658 or 90659, and it already has on record a claim with a **different** carrier number, but same HIC number, same date of service, and any one of those same HCPCS codes, the second claim submitted to CWF will reject.

If CWF receives a claim with HCPCS code 90732 and it already has on record a claim with the same HIC number, different carrier number, same date of service, and the same HCPCS code, the second claim submitted to CWF will reject.

If CWF receives a claim with HCPCS administration codes G0008 or G0009 and it already has on record a claim with a different carrier number, but the same HIC number, same date of service, and same procedure code, CWF will reject the second claim submitted.

CWF will return a specific reject code for this edit that will be named in the CWF documentation. Carriers must deny the second claim. For the second edit, the reject code should automatically trigger the following Medicare Summary Notice (MSN) and Remittance Advice (RA) messages.

- MSN: 7.2 – “This is a duplicate of a claim processed by another contractor. You should receive a Medicare Summary Notice from them.”

- RA: At the service level, report adjustment reason code 23 – Payment adjusted because charges have been paid by another payer.

10.4.3 - CWF A/B Crossover Edits for FI and Carrier Claims

(Rev. 1, 10-01-03)

B3-4480.5, R1801.B.3

When CWF receives a claim from the carrier, it will review Part B outpatient claims history to verify that a duplicate claim has not already been posted.

CWF will edit on the beneficiary HIC number; the date of service; the flu procedure codes 90657, 90658, or 90659; the pneumonia procedure code 90732; and the administration code G0008 or G0009.

CWF will return a specific reject code for this edit that will be named in the CWF documentation. Carriers and FIs must deny the second claim and use the same messages they currently use for the denial of duplicate claims.

10.5 - Medicare Summary Notice (MSN)

(Rev. 1, 10-01-03)

AB-01-155A

FIs and carriers must generate a Medicare Summary Notice (MSN) for PPV, influenza, hepatitis B vaccines, and their administration.

For vaccines rendered to beneficiaries other than PPV, influenza virus or hepatitis B, which are not covered by Medicare, they must send the following MSN message.

MSN: 18.2:

> This immunization and/or preventive care is not covered.

The Spanish version of this MSN message should read:

> Esta inmunización y/o servicios preventivos no están cubiertos.

20 - Screening Mammography Services

(Rev. 337, Issued: 10-29-04, Effective: 04-01-05, Implementation: 04-04-05)

A. Screening Mammography

Beginning January 1, 1991, Medicare provides Part B coverage of screening mammographies for women. Screening mammographies are radiologic procedures for

early detection of breast cancer and include a physician's interpretation of the results. A doctor's prescription or referral is not necessary for the procedure to be covered. Whether payment can be made is determined by a woman's age and statutory frequency parameter. See Pub 100-02 Medicare Benefit Policy Manual, chapter 15, section 280.3 for additional coverage information for a screening mammography.

Section 4101 of the Balanced Budget Act (BBA) of 1997 provides for annual screening mammographies for women over age 39 and waives the Part B deductible. Coverage applies as follows:

Age Groups	**Screening Period**
Under age 35	No payment allowed for screening mammography.
35-39	Baseline (pay for only one screening mammography performed on a woman between her 35th and 40th birthday)
Over age 39	Annual (11 full months have elapsed following the month of last screening

NOTE: Count months between screening mammographies beginning the month after the date of the examination. For example, if Mrs. Smith received a screening mammography examination in January 2005, begin counting the next month (February 2005) until 11 months have elapsed. Payment can be made for another screening mammography in January 2006.

B. Diagnostic Mammography

A diagnostic mammography is a radiological mammogram and is a covered diagnostic test under the following conditions:

- A patient has distinct signs and symptoms for which a mammogram is indicated;
- A patient has a history of breast cancer; or
- A patient is asymptomatic, but based on the patient's history and other factors the physician considers significant, the physician's judgment is that a mammogram is appropriate.
- Beginning January 1, 2005, Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, § 644, Public Law 108-173 has changed the way Medicare pays for diagnostic mammography. Medicare will pay based on the MPFS in lieu of OPPS or the lower of the actual change.

20.1 - Mammography Quality Standards Act (MQSA)

(Rev. 1, 10-01-03)

A3-3660.16, B3-4601.2.D, B3-4601.3, SNF-537.1, SNF-537.1.A, SNF-537.1.B, SNF-537.1.D, SNF-538, HO-454, RHC-641

The law provides specific standards regarding those qualified to perform screening and diagnostic mammograms and how they should be certified. The Mammography Quality Standards Act (MQSA) requires the Secretary to ensure that all facilities that provide mammography services meet national quality standards. Effective October 1, 1994, all facilities providing screening and diagnostic mammography services (except VA facilities) must have a certificate issued by the Food and Drug Administration (FDA) to continue to operate. The FDA, Center for Devices and Radiological Health, is responsible for collecting certificate fees and surveying mammography facilities (screening and diagnostic).

The FDA provides CMS with a listing of all providers that have been issued certificates to perform mammography services and CMS notifies contractors accordingly. Contractors are also notified of situations where a provider's certificate has expired, or has been suspended or revoked. The information provided includes the provider's name, address, 6-position certification number, and effective/termination dates.

Medicare will only reimburse FDA-certified mammography centers. Carriers must inform physicians and suppliers at least annually, through their provider/supplier publications, of those facilities centers, which are certified. Carriers encourage physicians to inform their patients about centers that are certified.

Mammography facilities that perform screening mammographies are **not** to release screening mammography x-rays for interpretation to physicians who are not approved under the facility's certification number unless the patient has requested a transfer of the films from one facility to another for a second opinion, or unless the patient has moved to another part of the country where the next screening mammography will be performed. Interpretations are to be performed **only** by physicians who are associated with the certified mammography facility. Carriers are not required to maintain a list of these associations unless there is a specific reason for doing so and only on a case-by-case basis.

When adjudicating a screening mammography claim, contractors refer to the table of certified facilities provided by FDA and confirm that the facility listed on the claim is in fact certified to perform the service. When the contractor determines that the facility that performed the mammography service has not been issued a certificate by FDA or the certificate is suspended or revoked, the claim will be denied utilizing the denial language in §20.8.1 of this chapter, related to certified facilities.

20.1.1 - Under Arrangements

(Rev. 1, 10-01-03)

SNF-537.1.C

When mammography services are obtained for patients under arrangements with another facility, the provider arranging the service must ensure that the facility performing the services has been issued a MQSA certificate by FDA.

20.1.2 – MQSA File

(Rev. 33, 11-28-03)

Prior to April 1, 2003, the MQSA file showed all facilities that are certified to perform film screening and diagnostic mammograms. After April 1, 2003, the file shows a new Record Type with two indicators, "1" for film and "2" for digital to determine which mammograms the facility is certified to perform.

Section 104 of the Benefits Improvement and Protection Act (BIPA) of 2000, entitled "Modernization of Screening Mammography Benefit," provided new payment methodologies for both diagnostic and screening mammograms that utilize digital technology. The new digital mammography codes have a higher payment rate. In order for Medicare to know whether the mammography facility is certified to perform digital mammography and, therefore, due a higher payment rate, the FDA will send an updated file via CMS Mainframe Telecommunications System (CMSTS), formerly Network Data Mover, on a weekly basis.

Effective April 1, 2003, the file shows:

- Name of Facility,
- Certification number of the facility,
- Film certification obtained (Record-type =1) or digital certification obtained (Record-type = 2), and
- Effective and Expiration dates of each certification.

Some mammography facilities are certified to perform both film and digital mammography. In this case, the facility's name and FDA certification number shows up on this file twice. One line will indicate film certification with effective date/expiration date while the other line will indicate digital certification with effective date/expiration date. The facilities may not have the same effective date and expiration date for both film and digital certification.

NOTE: FDA does not issue printed certification which indicates film or/and digital. Refer to the MQSA file for proof of types of mammography the facility is certified to perform.

Medicare pays for film mammography and digital mammography at different rates and pays for a service only if the provider or supplier is certified by the FDA to perform those types of mammogram for which payment is sought. If the FDA mammography file has an

error, contact your regional office mammography coordinator. The coordinators will contact the FDA to research the error. The FDA file is transmitted weekly.

In order to implement these procedures take the following steps:

1) The contractors must use the updated file to match the mammography certification number to a provider for validity to adjudicate claims.

2) When a film mammography HCPCS code comes in on a claim, check for a "1" film indicator.

- If a film mammography HCPCS code comes in on a claim and the facility is certified for film mammography, pay the claim.

- If a film mammography HCPCS code comes in on a claim and the facility is certified for digital mammography only, return to provider (RTP).

- If a film mammography HCPCS code comes in on a claim and there is no certification number on the claim, return to provider (RTP) (carriers only).

3) When a digital mammography HCPCS code comes in on a claim, check for "2" digital indicator.

- If a digital mammography HCPCS code comes in on a claim and the facility is certified for digital mammography, pay the claim.

- If a digital mammography HCPCS code comes in on a claim and the facility is certified for film mammography only, return to provider (RTP).

- If a digital mammography HCPCS code comes in on a claim and there is no certification number on the claim, return to provider (RTP) (carriers only).

NOTE: Refer to §20.2 for a complete listing of mammography HCPCS codes.

4) Common Working File (CWF) no longer receives the mammography file for editing purposes.

20.2 - HCPCS and Diagnosis Codes for Mammography Services

(Rev. 705, Issued: 10-07-05; Effective: 01-01-98; Implementation: 07-05-05)

The following HCPCS and TOS codes are used to bill for mammography services.

HCPCS Code	TOS	Definition
76082	4	Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images, diagnostic mammography (list separately in addition to code for primary procedure). **Effective January 1, 2004.**
76083	1	Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images, screening mammography (list separately in addition to code for primary procedure). **Effective January 1, 2004.**
76085	1	Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation screening mammography (list separately in addition to code for primary procedure). Use with CPT code 76092 **Code 76085 was effective 1-1-2002 for all claims submitted to a carrier or an FI, except hospital outpatient prospective payment (OPPS) claims, which are billed to the FI. For OPPS claims billed to the FI, this code is effective 4-1-2002. Deleted as of December 31, 2003.**
76090	1	Diagnostic mammography, unilateral.
76091	1	Diagnostic mammography, bilateral.
76092	1, B, C	Screening mammography, bilateral (two view film study of each breast).
G0202	1	Screening mammography, producing direct digital image, bilateral, all views. **Code Effective 4-1-2001.**
G0203		Screening mammography film processed to produce digital images analyzed for potential abnormalities, bilateral all views; **Code Effective 4-1-2001 and terminated 12-31-2001, with the exception of hospitals subject to OPPS, who may bill this code through 3-31-02.**
G0204	4	Diagnostic mammography, direct digital image, bilateral, all views; **Code Effective 4-1-2001.**
G0205		Diagnostic mammography, film processed to produce digital

HCPCS Code	TOS	Definition
		image analyzed for potential abnormalities, bilateral, all views; **Code Effective 4-1-2001 and terminated 12-31-2001, with the exception of hospitals subject to OPPS, who may bill this code through 3-31-02.**
G0206	1	Diagnostic mammography, producing direct digital image, unilateral, all views; **Code Effective 4-1-2001.**
G0207		Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all views; **Code Effective 4-1-2001 and terminated 12-31-2001, with the exception of hospitals subject to OPPS, who may bill this code through 3-31-02.**
G0236		Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography (List separately in addition to code for primary procedure). Use with CPT Codes 76090 or 76091. **Code G0236 was effective 1-1-2002 for all claims submitted to a carrier or an FI except hospital OPPS claims, which are billed to the FI. For OPPS claims billed to the FI, the code is effective 4-1-2002. Deleted as of December 31, 2003.**

New Modifier "-GG": Performance and payment of a screening mammography and diagnostic mammography on same patient same day - This is billed with the Diagnostic Mammography code to show the test changed from a screening test to a diagnostic test. Contractors will pay both the screening and diagnostic mammography tests. This modifier is for tracking purposes only. This applies to claims with dates of service on or after January 1, 2002.

A. Diagnosis for Services On or After January 1, 1998

The BBA of 1997 eliminated payment based on high-risk indicators. However, to assure proper coding, one of the following diagnosis codes should be reported on screening mammography claims as appropriate:

> V76.11 – "Special screening for malignant neoplasm, screening mammogram for high-risk patients" or;
>
> V76.12 - "Special screening for malignant neoplasm, other screening mammography."

Beginning October 1, 2003, carriers are no longer permitted to plug the ICD-9-CM code for a screening mammography when the screening mammography claim has no diagnosis

code. Screening mammography claims with no diagnosis code must be returned as unprocessable for assigned claims. For unassigned claims, deny the claim.

FI claims receive the diagnosis in FL 67, "Principal Diagnosis Code" of Form CMS-1450. Carriers receive this diagnosis in field 21 of Form CMS-1500.

Diagnosis codes for a diagnostic mammography will vary according to diagnosis.

B. Diagnoses for Services October 1, 1997 Through December 31, 1997

On every screening mammography claim where the patient is not a high-risk individual, diagnosis code V76.12 is reported on the claim.

If the screening is for a high risk individual, the provider reports the principal diagnosis code as V76.11 - "Screening mammogram for high risk patient."

In addition, for high-risk individuals, one of the following applicable diagnoses codes is reported as "Other Diagnoses codes" (Form CMS-1450, FL 68)

- V10.3 "Personal history - Malignant neoplasm female breast";
- V16.3 "Family history - Malignant neoplasm breast"; or
- V15.89 "Other specified personal history representing hazards to health."

The following chart indicates the ICD-9 diagnosis codes reported for each high-risk category:

High Risk Category	Appropriate Diagnosis Code
A personal history of breast cancer	V10.3
A mother, sister, or daughter who has breast cancer	V16.3
Not given birth prior to age 30	V15.89
A personal history of biopsy-proven benign breast disease	V15.89

20.2.1 - Computer-Aided Detection (CAD) Add-On Codes

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

Screening Add-on Codes 76085 and 76083

Effective for services on or after January 1, 2002 through December 31, 2003, (or April 1, 2002 for hospitals subject to OPPS) a new CPT code 76085, CAD conversion of

standard film images to digital images has been established as an add-on code that can be billed only in conjunction with the primary service screening mammography code 76092. The definition of 76085 is: "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, mammography (list separately in addition to code for primary procedure)."

NOTE: For claims with dates of service April 1, 2003 – December 31, 2003, code G0202 may be billed in conjunction with 76085.

Carriers and FIs make payment under the Medicare physician fee schedule. There is no Part B deductible. However, coinsurance is applicable.

For claims with dates of service April 1, 2005, and later, hospitals bill for code 76083 under the 13X bill type. The 14X bill type *is* no longer applicable. Appropriate TOBs for providers other than hospitals are 22x, 23x, and 85x.

Contractors must assure that claims containing code 76085 also contain HCPCS code 76092 or G0202. If not, FIs return claims to the provider with an explanation that payment for code 76085 cannot be made when billed alone. Carriers deny payment for 76085 when billed without 76092 or G0202.

NOTE: When screening CAD 76085 is billed in conjunction with a screening mammography (76092 or G0202) and the screening mammography (76092 or G0202) fails the age and frequency edits in CWF, both services will be rejected by CWF.

Effective with claims with dates of service January 1, 2004 and later, HCPCS code 76083, "Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation with or without digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure)," can be billed in conjunction with the primary service mammography code 76092 or G0202.

Contractors must assure that claims containing code 76083 also contain HCPCS code 76092 or G0202. FIs return claims containing code 76083 that do not also contain HCPCS code 76092 or G0202 with an explanation that payment for code 76083 cannot be made when billed alone. Carriers deny payment for 76083 when billed without 76092 or G0202.

NOTE: When screening CAD 76083 is billed in conjunction with a screening mammography (76092 or G0202) and the screening mammography (76092 or G0202) fails the age and frequency edits in CWF, both services will be rejected by CWF.

Diagnostic Add-on Codes G0236 and 76082

Effective for services on or after January 1, 2002 thru December 31, 2003, (or April 1, 2002 for hospital claims subject to OPPS*),* HCPCS code G0236 was established for diagnostic mammography CAD that can be billed only on the same claim with the

primary service of either 76090 or 76091. The definition of G0236 is: "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation." The code must be listed separately in addition to code for the primary procedure.

NOTE: For claims with dates of service April 1, 2003 - December 31, 2003, code G0204 and G0206 may be billed in conjunction with G0236.

For claims with dates of service April 1, 2005, and later, hospitals bill for code 76082 under the 13X bill type. The 14X bill type *is* no longer applicable. Appropriate TOBs for providers other than hospitals are 22x, 23x, and 85x.

There are no frequency limitations on diagnostic tests or CAD-diagnostic tests.

Contractors must assure that claims containing code G0236 also contain HCPCS code 76090, 76091, G0204, or G0206. If not, FIs return claims to the provider with an explanation that payment for code G0236 cannot be made when billed alone. Carriers deny payment for G0236 when billed without 76090, 76091, G0204 or G0206.

Effective with claims with dates of service January 1, 2004 and later, HCPCS code 76082, "Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation with or without digitization of film radiographic images; diagnostic mammography (list separately in addition to code for primary procedure)," can be billed in conjunction with the primary service mammography code 76090, 76091, G0204, or G0206.

Contractors must assure that claims containing code 76082 also contain HCPCS codes 76090, 76091, G0204 or G0206. FIs return claims containing code 76082 that do not also contain HCPCS code 76090, 76091, G0204, or G0206 with an explanation that payment for code 76082 cannot be made when billed alone. Carriers deny payment for 76082 when billed without 76090, 76091, G0204, or G0206.

20.2.1.1 - CAD Billing Charts

(Rev. 482, Issued 02-18-05, Effective/Implementation: Not Applicable)

The following chart provides guidance for billing of CAD add-on codes. It reflects appropriate coding combinations that may be billed and the time frames associated with each.

Chart I – Screening CAD Codes

CAD Codes	Effective 01-01-02 thru 03-31-03	Effective 04-01-03 thru 12-31-03	Effective 01-01-04 and later

76085	76092	76092, G0202	N/A
76083	N/A	N/A	76092, G0202

Chart II – Diagnostic CAD Codes

CAD Codes	**Effective 01-01-02 thru 03-31-03**	**Effective 04-01-03 thru 12-31-03**	**Effective 01-01-04 and later**
G0236	76090	76090	N/A
	76091	76091	
		G0204	
		G0206	
76082	N/A	N/A	76090
			76091
			G0204
			G0206

The CWF Application of Age and Frequency Edits, --The following chart reflects proper application of CWF age and frequency edits applied to CADs billed in conjunction with screening mammographies.

CAD Codes	**Effective 01-01-02 thru 03-31-03**	**Effective 04-01-03 thru 12-31-03**	**Effective 01-01-04 and later**
76085	76092	76092, G0202	N/A

76083	N/A	N/A	76092, G0202

See section 20.5.1, for carrier CWF edits

20.3 - Payment

(Rev. 1, 10-01-03)

A3-3660.10.B, B3-4601.2, B3-4601.2.E, B3-5266, SNF-537.A-F, SNF-537.2.B, HO-451.B-F, RHC-623.B-E, B3-5266B.1.c, B3-5266B.2.c, or B3-5266B.3.c, B3-5258, SNF-537.2.E

There is no Part B deductible for screening mammographies, however, coinsurance is applicable. The purchased service limit on physician billing for diagnostic tests does not apply to these services. Following are three categories of billing for mammography services:

- Professional component of mammography services (that is the physician's interpretation of the results of the examination);
- Technical component (all other services); or
- Both professional and technical components (global). However, global billing is not permitted for services furnished in provider outpatient departments, except for CAHs electing the optional method of payment for mammography services furnished on or after January 1, 2002.

20.3.1 - Payment for Screening Mammography Services Provided Prior to January 1, 2002

(Rev. 482, Issued 02-18-05, Effective/Implementation: Not Applicable)

Claims with dates of service prior to January 1, 2002, are subject to a payment limitation. The professional component is 32 percent of the total limit for the complete service. The technical component is 68 percent.

When the technical and professional components of the screening mammography are billed separately, the payment limit is adjusted to reflect either the professional or technical component only. That is, the limitation applicable to global billing for screening is allocated between the professional and technical components as set forth by regulations. Below are the limitation amounts applicable each calendar year:

Calendar Year	Global Payment Limit	Technical Component Amount	Professional Component Amount
1996	$62.10	$42.23	$19.87

Calendar Year	Global Payment Limit	Technical Component Amount	Professional Component Amount
1997	$63.34	$43.07	$20.27
1998	$64.73	$44.02	$20.71
1999	$66.22	$45.03	$21.19
2000	$67.81	$46.11	$21.69
2001	$69.23	$47.08	$22.15

NOTE: The CMS annually updates the overall limit annually by the percentage increase in the Medicare Economic Index.

EXAMPLE: In calendar year 2001, 32 percent of the $69.23 limit, or $22.15, is used in determining payment for the professional component; and 68 percent of the $69.23 limit, or $47.08, is used in determining payment for the technical component.

FI Payment

Payment for the **technical component** equals 80 percent of the least of the:

- The actual charge for the technical component (HCPCS code 76092) of the service;
- The physicians' fee schedule amount for the technical component of HCPCS code 76091 (a bilateral diagnostic mammogram); or
- The technical portion of the screening mammography limit as identified in the chart above.

Carrier Payment - Technical Component

Payment for the **technical component** equals 80 percent of the least of:

- The actual charge for the technical component of the service;
- The amount determined with respect to the technical component for the service under Medicare Physicians' Fee Schedule; or
- The technical portion of the screening mammography limit as identified in the chart above.

Carrier Payment - Professional Component

The amount of payment for the **professional** charge equals 80 percent of the least of:

- The actual charge for the professional component;
- The amount determined with respect to the professional component for the service under the Medicare Physician Fee Schedule; or
- The professional portion of the screening mammography limit based on the year of service according to the chart above.

FI or Carrier Payment - Global

The amount of payment for the **global charge** equals 80 percent of the least of:

- The actual charge for the procedure;
- The amount determined with respect to the global procedure under the Medicare Fee Schedule; or
- The limit for the procedure based on the year of service according to the chart above.

Carriers may receive bills for global, professional, or technical components. If mammography services are furnished by nonparticipating physicians and suppliers, there is a special limiting charge. Carriers must apply the appropriate payment reductions to screening mammography procedures furnished by new physicians.
Providers bill the technical component of mammography services to FIs. Only a CAH may bill globally if the CAH elected the optional method of payment for mammography services furnished on or after January 1, 2002.

FI Payment Example

$90.00	Provider charges for HCPCS;
$75.00	Physician' fee schedule amount; and
$47.08	Technical portion of the screening mammography limit (68% of $69.23 (year 2001))

Payment is 80 percent of the lower of the following amounts. To calculate the payment, select the lower of:

$90.00	Provider charges;

$75.00	Physician' fee schedule amount for the technical component; or
$47.08	Technical portion of the screening mammography limit (year 2001).

Payment is 80 percent of the remainder. FIs do not apply the provider's interim rate. This is a final payment to the provider. In this example, payment is calculated as follows:

$47.08 x 80% = $ 37.66 payment to the provider

To determine the patient's liability, multiply the actual charge by 20 percent. The result is the patient's liability. In this example, the calculation is:

$90.00 x 20% = $18.00 (coinsurance).

20.3.2 - Payment for Screening Mammography Services Provided On and After January 1, 2002

(Rev. 482, Issued 02-18-05, Effective/Implementation: Not Applicable)

The payment limitation methodology does not apply to claims with dates of service on or after January 1, 2002.

FI Claims

For claims with dates of service on or after January 1, 2002, §104 of the Benefits Improvement and Protection Act (BIPA) 2000, provides for payment of screening mammography under the Medicare physician fee schedule (MPFS) when furnished in hospitals, skilled nursing facilities (SNFs), and CAHs not electing the optional method of payment for outpatient services. However, payment under the physician fee schedule is not applicable to hospitals subject to the Outpatient Prospective Payment System (OPPS) until April 1, 2002.

The payment for code 76092 is equal to the lower of

- The actual charge or
- Locality specific technical component payment amount under the MPFS.

Program payment for the service is 80 percent of the lower amount and coinsurance is 20 percent. Part B deductible does not apply. This is a final payment.

FIs use the benefit-pricing file provided by CMS to pay mammography codes.
Payment for the add-on code 76085 is made under the Medicare Physician Fee Schedule. Deductible does not apply, however, coinsurance is applicable.

Carrier Claims

Physicians and suppliers are paid by the carrier for all mammography tests (including screening mammography) under the MPFS. Separate prices for the technical component, the professional component and the global service are included on the MPFS.

The Medicare allowed charge is the lower of:

- The actual charge, or
- The MPFS amount for the service billed.

The Medicare payment for the service is 80 percent of the allowed charge. Coinsurance is 20 percent of the lower of the actual charge or the MPFS amount. Part B deductible is waived and does not apply to screening mammography.

As with other MPFS services, the nonparticipating provider reduction and the limiting charge provisions apply to all mammography tests (including screening mammography).

20.3.2.1 - Outpatient Hospital Mammography Payment Table

(Rev. 482, Issued 02-18-05, Effective/Implementation: Not Applicable)

Payment for Mammography in the Hospital Outpatient PPS Setting. For all other hospitals, the effective date for column 1 is April 1, 2001, through December 31, 2001, and for column 2, the effective date is January 2002.

PAYMENT FOR SCREENING MAMMOGRAPHY

Screening Mammography (Revenue Code 403)	**Year 2000**	**2001 (April 1, 01 thru March 31, 2002)**	**April 1, 2002 - forward**
76092 Screening Mammography, bilateral No deductible, Coinsurance applies	Lesser of: 1. Charges, 2. TC of PFS for 76091, or 3. Annual payment limit	Lesser of: 1. Charge, 2. TC of MPFS for code 76091, or 3. Annual payment limit $47.08	Lesser of: 1. Charge, or 2. TC of MPFS for code 76092
G0202 Screening Mammography, producing direct digital	N/A	Lesser of: 1. Charge, or	Lesser of: 1. Actual charge, or

Screening Mammography (Revenue Code 403)	**Year 2000**	**2001 (April 1, 01 thru March 31, 2002)**	**April 1, 2002 - forward**
image, bilateral, all views. No deductible Coinsurance applies		2. 150% TC of MPFS for code 76091	2. TC of MPFS for code G0202
G0203 Screening mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views. No Deductible Coinsurance Applies	N/A	Lesser of: 1. Charge, 2. TC of MPFS for code 76091, or 3. $57.28 (annual $ limit of $47.08 plus $10.20TC add on)	N/A

PAYMENT FOR DIAGNOSTIC MAMMOGRAPHY

Diagnostic Mammography (Revenue Code 401)	**Year 2000**	**2001 (April 1 - March 31, 2002)**	**April 1, 2002**	**January 1, 2005**
76091 Mammography, bilateral Deductible and coinsurance apply	OPPS (beginning Aug.1, 2000)	OPPS	OPPS	Lesser of charge or TC or the MPFS for 76091
76090 Mammography, bilateral Deductible and coinsurance apply	OPPS (beginning Aug.1, 2000)	OPPS	OPPS	Lesser of charge or TC or the MPFS for 76090
G0204 Diagnostic Mammography, direct digital image, bilateral, all views Deductible and coinsurance apply	N/A	Lesser of: 1. Charge, or 2. 150% TC of MPFS for code 76091	OPPS	Lesser of charge or TC or the MPFS for G0204
G0206 Diagnostic Mammography, direct digital image, unilateral, all views Deductible and coinsurance apply	N/A	OPPS (same APC as 76090)	OPPS	Lesser of charge or TC or the MPFS for G0206
G0205 Diagnostic Mammography, film processed to produce digital image analyzed for potential abnormalities,	N/A	Lesser of: 1. Charge, 2. TC of MPFS for code 76091, or	N/A	N/A

Diagnostic Mammography (Revenue Code 401)	Year 2000	2001 (April 1 - March 31, 2002)	April 1, 2002	January 1, 2005
unilateral, all views Deductible and coinsurance apply		3. $57.28 (annual $ limit of $47.08 plus $10.20TC add on)		
G0207 Diagnostic Mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all views Deductible and coinsurance apply	N/A	OPPS (same APC as 76090)	N/A	N/A

Beginning January 1, 2005, Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, § 644, Public Law 108-173 has changed the way

Medicare pays for diagnostic mammography. Medicare payment will be based on the MPFS. Payment will no longer be made under the OPPS.

COMPUTER-AIDED DETECTION (CAD) DEVICES

Computer-aided Detection (CAD)	Year 2000	2001 (April 1 - Dec 31)	Year 2002 - 2003	January 1, 2004	January 1, 2005
76085* CAD with screening mammography (may bill with 76092) No deductible coinsurance applies	N/A	N/A	Lesser of: 1. Charge, or 2. TC of MPFS for code 76085	N/A	N/A

G0236* CAD with diagnostic mammography (may bill with 76090 or 76091) Deductible and coinsurance apply	N/A	N/A	OPPS	N/A	N/A
76083 CAD with screening mammography (may bill with 76092 or G0202) No deductible applies	N/A	N/A	N/A	Lesser of: 1. Charge, or 2. TC of MPFS for code 76083	Lesser of: 1. Charge, or 2. TC of MPFS for code 76083
76082 CAD with diagnostic mammography (may bill with 76090, 76091, G0204, or G0206) Deductible and coinsurance apply	N/A	N/A	N/A	OPPS	Lesser of: 1. Charge, or 2. TC of MPFS for code 76082

TC = technical component

MPFS= Medicare Physician Fee Schedule

OPPS= Outpatient Prospective Payment System

APC= Ambulatory Payment Classification

*Note that code 76085 is a deleted code as of December 31, 2003. The new code to be used for dates of service beginning January 1, 2004 and later is 76083. Code G0236 is a deleted code as of December 31, 2003. The new code to be used for dates of service beginning January 1, 2004 and later is 76082.

Beginning January 1, 2005, Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, § 644, Public Law 108-173 has changed the way Medicare pays for diagnostic CAD services. Medicare payment will be based on the MPFS. Payment will no longer be made under the OPPS.

20.3.2.2 - Payment for Computer Add-On Diagnostic and Screening Mammograms for FIs and Carriers

(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

Payment for computer add-on diagnostic mammogram HCPCS code G0236 or 76082 when billed with CPT code 76090, 76091, G0204, or G0206 is as follows:

Place/Provider of Service	Payment
Physician	Medicare physicians' fee schedule
Outpatient Hospital	Outpatient Prospective Payment System (OPPS)
Critical Access Hospital (CAH)	Reasonable Cost
SNF	Medicare physicians' fee schedule – technical component
Independent RHC	All-inclusive rate for professional component (codes 76090 and 76091*)
Freestanding FQHC	All-inclusive rate for professional component (codes76090 and 76091*)

* Only for dates of service prior to April 1, 2005.

* Effective for claims with dates of service on or after January 1, 2005 computer add-on diagnostic mammography services provided in a hospital are paid under the MPFS. Payment is no longer made under the OPPS.

Code G0236, "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography," for CAD has been established as an add on code that can be billed in conjunction with primary service code G0204 or G0206, as well as existing codes 76090 or 76091. The Part B deductible and coinsurance apply. HCPCS code G0236 is deleted as of December 31, 2003.

Effective for claims with dates of service January 1, 2004 and later, add-on HCPCS code 76082, "Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (list separately in addition to code for primary procedure)," can be billed in conjunction with primary

service codes G0204 or G0206 as well as codes 76090 or 76091. The Part B deductible and coinsurance apply.

The add-on code cannot be billed alone. FIs return to provider claims containing only codes G0236 or 76082 with an explanation that payment for code G0236 or 76082 cannot be made when billed alone.

Carriers deny the claim using remark code N122, "Mammography add-on code can not be billed by itself" (effective September 12, 2002).

Payment for computer add-on screening mammogram HCPCS code 76085 or 76083 when billed with CPT code 76092 or G0202 is as follows:

Place/Provider of Service	**Payment**
Physician	Medicare physicians' fee schedule
Outpatient Hospital	Medicare physicians' fee schedule
Critical Access Hospital (CAH)	Reasonable Cost
SNF	Medicare physicians' fee schedule – technical component
Independent RHC	All-inclusive rate for professional component (code 76092*)
Freestanding FQHC	All-inclusive rate for professional component (code 76092*)

* Only for dates of service prior to April 1, 2005.

Code 76085, "Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, screening mammography," for CAD has been established as an add on code that can be billed in conjunction with primary service code G0202 as well as 76092. HCPCS code 76085 is deleted as of December 31, 2003. The Part B Deductible does not apply. However, coinsurance is applicable. FIs use the benefit pricing file provided by CMS to pay the above codes where payment is based on the technical component of the Medicare physician fee schedule.

Effective for claims with dates of service January 1, 2004 and later, HCPCS code 76083, "Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure)," can be billed in conjunction with the primary service code G0202 as well as code 76092. There is no Part B deductible but coinsurance applies.

The add-on code cannot be billed alone. FIs return to provider claims containing only codes 76085 or 76083 with an explanation that payment for code 76085 or 76083 cannot be made when billed alone. Carriers deny the claim using remark code N122 "Mammography add-on code cannot be billed by itself" (effective September 12, 2002).

20.3.2.3 - Critical Access Hospital Payment

(Rev. 60, 01-09-04)

A3-3660.10.B, A3-3610.22.B.2, A3-3660.10.A

For the technical component, professional component should be billed with revenue code 097X and HCPCS code G0202, 79092, or 76085**,** (use 76083 for claims with dates of service January 1, 2004 and later**)**. Payment to a CAH for screening mammography is not subject to applicable Part B deductible, but coinsurance does apply. Both deductible and coinsurance apply on a diagnostic mammography.

Any deductible or coinsurance collected is deducted from the payment.

A. Under the Optional (All Inclusive) Method

Section 403(d) of the BBRA amended §1834(g) of the Act to permit a CAH to elect an optional method of payment for outpatient services. This option is effective for cost reporting periods beginning on or after October 1, 2001. A CAH may elect to be paid for outpatient services by reasonable costs for facility services and §202 of BIPA allows an amount equal to 115 percent of the allowed amount for professional component. (Costs related to professional services are excluded from the cost payment.)

CAHs electing the optional method of reimbursement bill the FI with type of bill 85X, revenue code 0403 and HCPCS code 76092. They also include the professional component on a separate line, repeating revenue code 0403 and HCPCS code 76092, and add modifier "-26" to designate the professional component.

Payment to the CAH will be the sum of the following amounts:

- The interim rate times the charge for facility services, plus
- 115% of the MPFS for the professional services, minus
- Any coinsurance collected by the CAH based on charges.

A screening mammogram furnished on or after January 1, 2002, by a CAH, under the optional method, is paid at 115 percent of the lesser of:

- 80 percent of the actual charges of the CAH for the screening mammography, including both the radiologic procedure and the physician's interpretation, or
- 80 percent of the global payment amount under the MPFS for the screening mammography.

CAHs who have elected the optional method of reimbursement may bill the carrier on the Form CMS 1500 for the global amount.

CAHs that have elected the optional method of payment for outpatient services are paid for the professional component (PC) of a diagnostic mammography furnished on or after January 1, 2002 at 115 percent of the lesser of:

- 80 percent of the actual charges of the CAH for the physicians interpretation of the diagnostic mammography, or

- 80 percent of the PC determined under the MPFS for the diagnostic mammography.

B. Under the Standard Method

CAHs reimbursed on the standard method of payment bill the technical component of a screening mammography to the FI on type of bill 85X, revenue code 0403 and HCPCS code 76092. Payment is eighty percent of the lesser of the fee schedule or the actual charge.

Professional services are billed to the carrier and paid based on the fee schedule by the carrier.

For claims with dates of service on or after January 1, 2002, §104 of the Benefits Improvement and Protection Act (BIPA) 2000, provides for payment of screening mammographies under the Medicare physician fee schedule (MPFS) in CAHs not electing the optional method of payment for outpatient services. The payment for code 76092 is equal to the lower of the actual charge or locality specific technical component payment amount under the MPFS. Program payment for the service is 80 percent of the lower amount and coinsurance is 20 percent. This is a final payment.

Payment to CAHs for diagnostic mammograms is based on reasonable cost.

20.3.2.3.1 – CAH Mammography Payment Table

(Rev. 60, 01-09-04)

Payment for Screening Mammography in the Critical Access Hospital Outpatient Setting

Method 1 (Standard)

	TOB	Rev Code	HCPCS	Payment
Services prior to cost reporting periods ending October 1, 2001 and services prior to July 1, 2001 (BIPA)				

	TOB	Rev Code	HCPCS	Payment
Technical Component Deductible does not apply. Coinsurance based on charge.	85X	403	76092	FI payment is 80% of the reasonable cost.
Professional Component Deductible does not apply. Coinsurance based on lower of MPFS or charge.			76092	Carrier payment is 80% of the lower of the charge or MPFS amount for the technical component.

Services on or after July 1, 2001 to January 1, 2002				
Technical Component Deductible does not apply. Coinsurance based on charge.	85X	403	76092	FI payment is 80% of the reasonable cost.
Professional Component Deductible does not apply. Coinsurance based on lower of MPFS or charge.			76092	Carrier payment is 80% of the lower of the charge or MPFS amount.
Services on or after January 1 2002				
Technical Component Deductible does not apply. Coinsurance based on charge.	85X	403	*76092 *76085 G0202	FI payment is 80% of the lower of the charge or the fee schedule amount.
Professional Component Deductible does not apply. Coinsurance based on lower of MPFS			*76092 *76085 G0202	Carrier payment is 80% of the lower of the charge or MPFS amount for the technical

or charge.				component. The new A3 states payment for 76092 is lower of charge or locality specific TECHNICAL component amount under MPFS.
*Codes must be billed together on the same claim. Also note that 76085 is deleted after December 31, 2003. Use code 76083 for claims with dates of service January 1, 2004 and later.				

Method 2 (Optional Method) - Option available with cost reporting periods starting on or after October 1, 2001 and dates of service on or after July 1, 2001.

	TOB	Rev Code	HCPCS	Payment
Services for cost reporting periods on or after October 1, 2001 and service dates on or after July 1 and prior to January 1, 2002				
Technical Component Deductible does not apply. Coinsurance based on charge.	85X	403	76092	FI payment is 80% of the reasonable cost. (Interim rate times charge)
Professional Component Deductible does not apply. Coinsurance based on charge.	85X	96X, or 97X or 98X	76092 with Modifier "-"26	FI payment is 115% of the lower of the charge or MPFS amount after coinsurance is deducted.
Professional Component service in a rural or urban HPSA area. Deductible does not apply. Coinsurance based on charge	85X	96X, or 97X or 98X	Modifier "-QB" or "-QU"	If HPSA area, FI payment is 115% of 110% of the lower of the charge or MPFS amount after coinsurance is deducted.
Services on or after January 1 2002				
Technical Component Deductible does not apply. Coinsurance based on charge.	85X	403	*76085 *76092 G0202	FI payment is 80% of the lower of the charge or the fee schedule amount.
Professional Component Deductible does not apply. Coinsurance based on lower of MPFS or charge.	85X	97X	*76085 *76092 G0202	FI pays 115% of 80% (that is 92%) of the lower of the charge or the MPFS amount.

	TOB	Rev Code	HCPCS	Payment
* Codes must be billed together on the same claim. Also note that 76085 is deleted after December 31, 2003. Use code 76083 for claims with dates of service January 1, 2004 and later.				

20.3.2.4 - SNF Mammography Payment Table

(Rev. 60, 01-09-04)

Payment for Part B Mammography in the Skilled Nursing Facility Setting

Screening Mammography (Revenue Code 0403)	Year 2000	2001 (April 1 - March 31, 2002)	April 1, 2002
76092 Screening Mammography, bilateral No deductible, Coinsurance applies	Lesser of: 1. Charges or, 2. TC of MPFS for 76091, or 3. Annual payment limit	Lesser of: 1. Charge or, 2. TC of MPFS for code 76091, or 3.Annual payment limit $47.08	Lower of: 1. Charge, or 2. TC of MPFS for code 76092
G0202 Screening Mammography, producing direct digital image, bilateral, all views. No deductible Coinsurance applies	N/A	Lower of: 1. Charge, or 2. 150% TC of MPFS for code 76091	Lower of: 1. Charge, or 2. TC of MPFS for code G0202
G0203 Screening mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views. No Deductible Coinsurance Applies	N/A	Lesser of: 1. Charge, 2. TC of MPFS for code 76091, or 3. $57.28 (annual $ limit of $47.08 plus $10.20TC add on)	Replaced by code 76085

Payment for Diagnostic Mammography

Diagnostic Mammography (Revenue Code 401)	**Year 2000**	**2001 (April 1-March 31, 2002)**	**April 1, 2002**
76091 Mammography, bilateral Deductible and coinsurance apply	Lower of charge or TC of MPFS	Lower of charge or TC of MPFS	Lower of charge or TC of MPFS
76090 Mammography, bilateral Deductible and coinsurance apply	Lower of charge or TC of MPFS	Lower of charge or TC of MPFS	Lower of charge or TC of MPFS
G0204 Diagnostic Mammography, direct digital image, bilateral, all views Deductible and coinsurance apply	N/A	Lower of: 1. Charge, or 2. 150% TC of MPFS for code 76091	Lower of charge or MPFS
G0206 Diagnostic Mammography, direct digital image, unilateral, all views Deductible and coinsurance apply	N/A	Lower of charge or MPFS	Lower of charge or MPFS
G0205 Diagnostic Mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all views Deductible and coinsurance apply	N/A	Lesser of: 1. Charge, 2. TC of MPFS for code 76091, or 3. $57.28 (annual $ limit of $47.08 plus $10.20TC add on)	Replaced by G0236

Diagnostic Mammography (Revenue Code 401)	**Year 2000**	**2001 (April 1-March 31, 2002)**	**April 1, 2002**
G0207 Diagnostic Mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all views Deductible and coinsurance apply	N/A	Lower of charge or MPFS	N/A

Computer-Aided Detection (CAD)

Computer-aided Detection (CAD)	**Year 2000**	**2001 (April 1-Dec 31)**	**Year 2002**
76085* CAD with screening mammography (may bill with 76092) No Deductible Coinsurance Applies	N/A	N/A	Lower of: 1. Charge or, 2. TC of MPFS for code 76085
G0236* CAD with diagnostic mammography (may bill w. 76090 or 76091). Deductible and coinsurance apply	N/A	N/A	SNFs cannot be paid for this service

TC = technical component

MPFS= Medicare Physician Fee Schedule

* 76085 and G0236 are deleted codes after December 31, 2003. Use code 76083 instead of 76085 and 76082 instead of G0236 for claims with dates of service January 1, 2004 and later.

20.4 - Billing Requirements - FI Claims

(Rev. 337, Issued: 10-29-04, Effective: 04-01-05, Implementation: 04-04-05)

Except as provided in the following sections for RHCs and FQHCs, the following procedures apply to billing for screening mammographies.

The technical component portion of the screening mammography is billed on Form CMS-1450 under bill type 13X, 22X, 23X or 85X using revenue code 0403 and HCPCS code 76092.

The technical component portion of the diagnostic mammography is billed on Form CMS-1450 under bill type 13X, 22X, 23X or 85X using revenue code 0401 and HCPCS code 76090 and 76091.

Separate bills are required for claims with dates of service prior to January 1, 2002. Providers include on the bill only charges for the mammography screening. Separate bills are not required for claims with dates of service on or after January 1, 2002.

See separate instructions below for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).

20.4.1 - Rural Health Clinics and Federally Qualified Health Centers

(Rev. 1, 10-01-03)

20.4.1.1 - RHC/FQHC Claims With Dates of Service Prior to January 1, 2002

(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

A. Provider-Based RHC and FQHC

For claims with dates of service prior to January 1, 2002, provider-based RHCs and FQHCs bill the FI for the technical component and their carrier for the professional component of the screening and diagnostic mammography. Provider-based RHCs and FQHCs use the base provider number and bill type (13X, 22X, 23X or 85X as appropriate) when billing the FI for this service. Payment is based on the payment method for the base provider - the limitation.

B. Independent RHCs and Freestanding FQHCs

Independent RHCs and freestanding FQHCs bill their carrier for both the technical and professional components. Payment is made based on the limitation.

20.4.1.2 - RHC/FQHC Claims With Dates of Service on or After January 1, 2002

(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

A. Provider-Based RHC & FQHC - Technical Component

The technical component of a screening or diagnostic mammography for provider-based RHCs/FQHCs is typically furnished by the base provider. The provider of that service bills the FI under bill type 13X, 22X, 23X or 85X as appropriate using their outpatient provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services). The appropriate revenue code for a screening mammography is 0403, and the appropriate HCPCS codes are 76085 and 76092. Payment is based on the payment method for the base provider.

The appropriate revenue code for a diagnostic mammography is 0401, and the appropriate HCPCS codes are 76090, 76091 and G0236*.

*G0236 is a deleted code after December 31, 2003. Use 76082 for claims with dates of service January 1, 2004 and later.

B. Independent RHCs and Freestanding FQHCs - Technical Component

The technical component of a screening or diagnostic mammography is outside the scope of the RHC/FQHC benefit. The practitioner that renders the technical service bills their carrier on Form CMS-1500. Payment is based on the MPFS.

C. Provider-Based RHC & FQHC, Independent RHCs and Freestanding FQHCs - Professional Component

For claims with dates of service on or after January 1, 2002 but before April 1, 2005, the professional component of a screening mammography furnished within an RHC/FQHC by a physician or nonphysician is considered an RHC/FQHC service. RHCs and FQHCs bill the FI under bill type 71X or 73X for the professional component along with revenue code 0403 and HCPCS code 76085* or 76092. Payment is made under the all-inclusive rate. Specific revenue coding and HCPCS coding is required for this service in order for CWF to perform age and frequency editing.

*76085 is a deleted code after December 31, 2003. Use 76083 for claims with dates of service on or after January 1, 2004 but before April 1, 2005.

For claims with dates of service on or after January 1, 2002 but before April 1, 2005, RHCs and FQHCs bill the FI under bill type 71X or 73X for the professional component of a diagnostic mammography along with revenue code 0401 and HCPCS codes 76090 or 76091.

Payment should not be made for a screening or diagnostic mammography unless the claim contains a related visit code. FIs should assure payment is not made for revenue

code 0403 (screening mammography) or 0401(diagnostic mammography). The claim must also contain a visit revenue code 0520 or 0521. Payment is made for the professional component under the all-inclusive rate for the line item reporting revenue code 0520 or 0521. No payment is made on the line item reporting revenue code 0403.

For claims with dates of service on or after April 1, 2005, the professional component of a screening mammography furnished within an RHC/FQHC by a physician or nonphysician is considered an RHC/FQHC service. RHCs and FQHCs bill the FI under bill type 71X or 73X for the professional component. Payment is made for the professional component under the all-inclusive rate. Additional revenue and HCPCS coding is no longer required for this service when RHCs/FQHCs are billing for the professional component. Use revenue code 0520 or 0521 as appropriate.

For claims with dates of service on or after April 1, 2005, RHCs and FQHCs bill the FI under bill type 71X or 73X for the professional component of a diagnostic mammography. Use revenue code 0520 or 0521 as appropriate. No HCPCS coding is required for the diagnostic mammography.

20.4.2 - FI Requirements for Nondigital Screening Mammographies

(Rev. 337, Issued: 10-29-04, Effective: 04-01-05, Implementation: 04-04-05)

The FI will consider the following when determining whether payment may be made:

- Presence of revenue code 0403;
- Presence of HCPCS code 76092;
- Presence of high risk diagnosis code indicator where appropriate;
- Date of last screening mammography; and
- Age of beneficiary.

The FIs must accept revenue code 0403 for bill types 13X, 22X, 23X, 71X, 73X, or 85X.

20.4.2.1 - FI Data for CWF and the Provider Statistical and Reimbursement Report (PS&R)

(Rev. 60, 01-09-04)

A3 0 3660.10.E, A3-3660.10.F

The CWF records are annotated with the date of the first (technical) screening mammography claim received. The record is updated based on the next covered (technical) claim received. Contractors assume the claim is the first received for the beneficiary where records do not contain a date of last screening and process accordingly.

The FIs include revenue code, HCPCS code, units, and covered charges in the CWF record fields with the same name. They report the payment amount for revenue code 0403 in the CWF field named "Rate" and the billed charges in the field named "Charges" of the CWF record. In addition, FIs report special override code 1 in the field named "Special Action" of the CWF record to avoid application of the Part B deductible.

When a screening CAD (76085*) is billed in conjunction with a screening mammography (76092) and the screening mammography (76092 or G0202) fails the age and frequency edits in CWF, both services will be rejected by CWF.

*76085 is a deleted code after December 31, 2003. Use 76083 for claims with dates of service January 1, 2004 and later.

The FIs include in the financial data portion of the PS&R record, revenue code, HCPCS code, units, charges, and rate (fee schedule amount).

The PS&R system will include screening mammographies on a separate report from cost-based payments. See the PS&R guidelines for specific information.

20.5 - Carrier Processing Requirements

(Rev. 60, 01-09-04)

B3-4601.3, B3-4601.3.A

Carriers complete the following activities in processing mammography claims:

- Process the claim to the point of payment based on the information provided on the claim and in carrier claims history.
- Identify the claim as a screening mammography claim by the CPT-4 code listed in field 24D and the diagnosis code(s) listed in field 21 of Form CMS-1500.
- Confirm that the facility listed on the claim is certified to perform the service for Medicare beneficiaries.
- Assigned physician specialty code 45 to facilities who are certified to perform only screening mammography.
- Ensure that entities that bill globally for screening mammography contain a blank in modifier position #1.
- Ensure that entities that bill for the technical component use only HCPCS modifier "-TC."
- Ensure that physicians who bill the professional component separately use HCPCS modifier "-26."

- Send the mammography modifier to CWF in the first modifier position on the claim. If more than one modifier is necessary, e.g., if the service was performed in a rural Health Manpower Shortage Area (HMSA) facility, instruct providers to bill the mammography modifier in modifier position 1 and the rural (or other) modifier in modifier position 2.

- Ensure all those who are qualified include the 6-digit FDA assigned certification number of the screening center in field 32 of Form CMS-1500 and in field 31 on the electronic NSF. Carriers retain this number in their provider files.

- Handle a claim according to current rules if it is determined that a facility is not FDA-certified. A provider/facility must have FDA certification to be reimbursed by Medicare. FDA certification number must be on the claim and match the FDA file forwarded to contractors.

- Waive Part B deductible and apply coinsurance for a screening mammography.

- Add diagnosis code V76.12 if a claim comes in for screening mammography without a diagnosis and the carrier file data shows this is appropriate. If there are other diagnoses on the claim, but not code V76.12, add it. (Do not change or overlay code V76.12 but ADD it). At a minimum, edit for age, frequency, and place of service (POS).

NOTE: Beginning October 1, 2003, carriers are no longer permitted to plug the ICD-9 code for a screening mammography when the screening mammography claim has no diagnosis code. Screening mammography claims with no diagnosis code must be returned as unprocessable for assigned claims. For unassigned claims, deny the claim.

Carrier Provider Education

- Educate providers that when a screening mammography turns to a diagnostic mammography on the same day for the same beneficiary, add the "-GG" modifier to the diagnostic code and bill both codes on the same claim. Both services are reimbursable by Medicare.

- Educate providers that they cannot bill an add-on code without also billing for the appropriate mammography code. If just the add-on code is billed, the service will be denied. Both the add-on code and the appropriate mammography code should be on the same claim.

20.5.1 - Part B Carrier Claim Record for CWF

(Rev. 60, 01-09-04)

B3-4601.3.B

Carriers complete the type of service field in the CWF Part B claim record with a “B” if the patient is a high risk screening mammography patient or a “C” if she is a low risk screening mammography patient for services prior to January 1, 1998.

For services on or after January 1, 1998, the type of service field on CWF must have a value of “1” for medical care (screening) or a “4” for diagnostic radiology (diagnostic). Fill in POS. Fill in deductible indicator field with a “1”; not subject to deductible if screening mammography. Submit the claim to the CWF host. Trailer 17 of the Part B Basic Reply record will give the date of the last screening mammography.

The CWF edits for age and frequency for screening mammography. There are no frequency limitations on diagnostic tests or CAD-diagnostic tests. When a screening CAD is billed in conjunction with a screening mammogram and the screening mammogram fails the age or frequency edits then both services will be rejected.

20.5.1.1 – Carrier and CWF Edits

(Rev. 60, 01-09-04)

The CWF will not edit for POS for screening mammography. Disable 76X1 edit. Add-on CAD Code 76083 must be billed in conjunction with screening mammography code 76092 or G0202 for claims with dates of service on or after January 1, 2004. Use

Type of Service “1”.

Add-on CAD Code 76082 must be billed in conjunction with diagnostic mammography code 76090, 76091, G0204, or G0206 for claims with dates of service on or after January 1, 2004. Use Type of Service “4”.

Frequency edits apply to screening mammography with or without the CAD code. Screening and diagnostic mammographies (film and digital) are subject to the FDA certification. However, CAD equipment does not require FDA Certification.

Correct Coding Initiative (CCI) Edits

Use modifier GG to allow both screening and diagnostic mammography to by-pass the CCI edits and pay. All Mammography CCI edits for Part B will be by-passed by CWF. CCI edits do not apply to mammography services.

20.5.2 - Transportation Costs for Mobile Units

(Rev. 1, 10-01-03)

B3-4601.2.J

Transportation costs are associated with mobile units for diagnostic mammography tests only. CMS formally added diagnostic mammography to the regulation language of the portable x-ray benefit in 42 CFR 410.32(c)(3). These units are usually reserved for

screening tests only. For the screening tests performed in a mobile unit, there is no separate transportation cost allowed. Carriers should investigate transportation costs associated with the mobile mammography diagnostic tests that exceed data analysis guidelines.

To receive transportation payments, the approved portable x-ray supplier must also meet the certification requirements of §354 of the Public Health Service Act.

20.6 - Instructions When an Interpretation Results in Additional Films

(Rev. 1, 10-01-03)

SNF-537.2.F, B3-4601.2.H, A3-3660.10.G, A3 -3660.10.H

A. Claims With Dates of Service October 1, 1998 Through December 31, 2001

A radiologist who interprets a screening mammography is allowed to order and interpret additional films based on the results of the screening mammogram while the beneficiary is still at the facility for the screening exam. Where a radiologist interpretation results in additional films, the mammography is no longer considered a screening exam for application of age and frequency standards or for payment purposes. This can be done without an additional order from the treating physician. When this occurs, the claim will be billed and paid as a diagnostic mammography instead of a screening mammography. However, since the original intent for the exam was for screening, for statistical purposes, the claim is considered a screening.

The claim should be prepared for FI processing reflecting the diagnostic revenue code (0401) along with HCPCS code 76090, 76091, G0204, G0206 or G0236 as appropriate and modifier "-GH" "Diagnostic mammogram converted from screening mammogram on same day." Statistics will be collected based on the presence of modifier "-GH." A separate claim is not required. Regular billing instructions remain in place for mammograms that do not fit this situation.

Carriers should receive a claim for a screening mammogram with CPT code 76092 (screening mammography, bilateral) (Type of Service =1) **but**, if the screening mammogram turns into a diagnostic mammogram, the claim is billed with CPT code 76090 (unilateral) or 76091 (bilateral), (TOS=4), with the "-GH" modifier. Carriers pay the claim as a diagnostic mammography instead of a screening mammography.

NOTE: However, the ordering of a diagnostic test by a radiologist following a screening test that shows a potential problem need not be on the same date of service.

In this case, where additional diagnostic tests are performed for the same beneficiary, same visit on the same day, the UPIN of the treating physician is needed on the carrier claim. The radiologist must refer back to the treating physician for his/her UPIN and also report to the treating physician the condition of the patient. Carriers need to educate radiologists and treating physicians that the treating physician's UPIN is required

whenever a physician refers or orders a diagnostic lab or radiology service. If no UPIN is present for the diagnostic mammography code, the carrier will reject the claim.

B. Claims With Dates of Service On or After January 1, 2002, (or On or After April 1, 2002 for Hospitals Subject to OPPS)

A radiologist who interprets a screening mammography is allowed to order and interpret additional films based on the results of the screening mammogram while a beneficiary is still at the facility for the screening exam. When a radiologist's interpretation results in additional films, Medicare will pay for both the screening and diagnostic mammogram.

Carrier Claims

For carrier claims, providers submitting a claim for a screening mammography and a diagnostic mammography for the same patient on the same day, attach modifier "-GG" to the diagnostic mammography. A modifier "-GG" is appended to the claim for the diagnostic mammogram for tracking and data collection purposes. Medicare will reimburse both the screening mammography and the diagnostic mammography.

FI Claims

FIs require the diagnostic claim be prepared reflecting the diagnostic revenue code (0401) along with HCPCS code 76090, 76091, G0204, G0206 or G0236 and modifier "-GG" "Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day." Reporting of this modifier is needed for data collection purposes. Regular billing instructions remain in place for a screening mammography that does not fit this situation.

Both carrier and FI systems must accept the GH and GG modifiers where appropriate.

20.7 - Mammograms Performed With New Technologies

(Rev. 337, Issued: 10-29-04, Effective: 04-01-05, Implementation: 04-04-05)

Section 104 of the Benefits Improvement and Protection Act 2000, (BIPA) entitled Modernization of Screening Mammography Benefit, provides for new payment methodologies for both diagnostic and screening mammograms that utilize advanced new technologies for the period April 1, 2001, to December 31, 2001 (to March 31, 2002 for hospitals subject to OPPS). Under this provision, payment for technologies that directly take digital images would equal 150 percent of the amount that would otherwise be paid for a bilateral diagnostic mammography. For technologies that convert standard film images to digital form, payment will be derived from the statutory screening mammography limit plus an additional payment of $15.00 for carrier claims and $10.20 for FI (technical component only) claims.

Payment restrictions for digital screening and diagnostic mammography apply to those facilities that meet all FDA certifications as provided under the Mammography Quality

Standards Act. However, CAD codes billed in conjunction with digital mammographies or film mammographies are not subject to FDA certification requirements.

Mammography related CAD equipment does not require FDA certification.

Mammography utilizes a direct x-ray of the breast. By contrast, the CAD process uses laser beam to scan the mammography film from a film (analog) mammography, converts it into digital data for the computer, and analyzes the video display for areas suspicious for cancer. The CAD process used with digital mammography analyzes the data from the mammography on a video display for suspicious areas. The patient is not required to be present for the CAD process.

Only one screening mammogram, either 76092 or G0202, may be billed in a calendar year. Therefore, providers/suppliers must not submit claims reflecting both a film screening mammography (76092) and a digital screening mammography G0202. Also, they must not submit claims reflecting HCPCS codes 76090 or 76091 (diagnostic mammography-film) and G0204 or G0206 (diagnostic mammography-digital). Contractors deny the claim when both a film and digital screening or diagnostic mammography is reported. However, a screening and diagnostic mammography can be billed together.

A. Payment Requirements for FI Claims With Dates of Service On or After April 1, 2001 Through December 31, 2001 (Through March 31, 2002 for Hospitals Subject to OPPS).

Providers bill the FI for the technical component of screening and diagnostic mammographies that utilize advanced technologies with one of six new HCPCS codes, G0202 - G0207. See payment methodology below for each of the codes during the period April 1, 2001 through December 31, 2001 (or March 31, 2002 for hospitals subject to OPPS). Payments for codes G0202 through G0205 are based, in part, on the MPFS payment amounts. The amounts that are based on the MPFS that both carriers and FIs use in calculating the payments for these codes were furnished in a BIPA mammography benefit pricing file for implementation on April 1, 2001.

HCPCS	Definition
G0202	Screening mammography producing direct digital image, bilateral, all views

Payment Method:

Payment will be the lesser of the provider's charge or the amount that will be provided for this code in the pricing file. (That amount is 150 percent of the locality specific technical component payment amount under the physician fee schedule for CPT code 76091, the code for bilateral diagnostic mammogram, during 2001.) Part B deductible does not apply. Coinsurance will equal 20 percent of the lesser of the actual charge or 150 percent of the locality specific payment of CPT code 76091.

HCPCS Definition

G0203 Screening mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views

Payment Method:

Payment will be equal to the lesser of the actual charge for the procedure, the amount that is provided in the pricing file (which represents 68 percent of the locality specific global payment amount for a bilateral diagnostic mammography (CPT 76091) under the physician fee schedule), or $57.28 (which represents the amount of the 2001 statutory limit for a screening mammography attributable to the technical component of the service, plus the technical portion of the $15.00 add-on for 2001 which is provided under the new legislation). Part B deductible does not apply. Coinsurance is 20 percent of the charge.

HCPCS Definition

G0204 Diagnostic mammography, direct digital image, bilateral, all views

Payment Method:

Payment will be the lesser of the provider's charge or the amount that will be provided for this code in the pricing file. (That amount is 150 percent of the locality specific amount paid under the physician fee schedule for the technical component (TC) of CPT code 76091, the code for a bilateral diagnostic mammogram.) Deductible is applicable. Coinsurance will equal 20 percent of the lesser of the actual charge or 150 percent of the locality specific payment of CPT code 76091.

NOTE: Effective January 1, 2005 payment will be made under MPFS for claims from hospitals subject to OPPS.

HCPCS Definition

G0205 Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views.

Payment Method:

Payment will be equal to the lesser of the actual charge for the procedure, the amount that will be provided in the pricing file (which represents 68 percent of the locality specific global payment amount for a bilateral diagnostic mammography (CPT 76091) under the physician fee schedule), or $57.28 (which represents the amount of the 2001 statutory limit for a screening mammography attributable to the technical component of the service, plus the technical portion of the $15.00 add-on for 2001 which is provided under the new legislation). Deductible applies. Coinsurance is 20 percent of the charge.

HCPCS	Definition
G0206	Diagnostic mammography, direct digital image, unilateral, all views.

Payment Method:

Payment will be made based on the same amount that is paid to the provider, under the payment method applicable to the specific provider type (e.g., hospital, rural health clinic, etc.) for CPT code 76090, the code for a mammogram, and one breast. For example, this service, when furnished as a hospital outpatient service, will be paid the amount under the outpatient prospective payment system (OPPS) for CPT code 76090. Deductible applies. Coinsurance is the national unadjusted coinsurance for the APC wage adjusted for the specific hospital.

NOTE: Effective January 1, 2005 payment will be made under MPFS for claims from hospitals subject to OPPS.

HCPCS	Definition
G0207	Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all views.

Payment Method:

Payment will be based on the same amount that is paid to the provider, under the payment method applicable to the specific provider type (e.g., hospital, rural health clinic, etc.) for CPT code 76090, the code for mammogram, and one breast. For example, this service, when furnished as a hospital outpatient service, will be paid the amount payable under the OPPS for CPT code 76090. Deductible applies. Coinsurance is the national unadjusted coinsurance for the APC wage adjusted for the specific hospital.

B. Payment Requirements for Claims with Dates of Service on or After January 1, 2002 (April 1, 2002 for hospitals subject to OPPS).

Codes G0203, G0205 and G0207 are not billable codes for claims with dates of service on or after January 1, 2002 (April 1, 2002 for hospitals subject to OPPS).

FI Payment

Code	Payment
G0202	Payment will be equal to the lower of the actual charge or the locality specific technical component payment amount under the MPFS when performed in a hospital outpatient department, CAH, or SNF. Coinsurance is 20 percent of the lower amount; the Program pays 80 percent. Deductible does not apply.
G0204	Payment will be made under OPPS for hospital outpatient departments. Coinsurance is the national unadjusted coinsurance for the APC wage adjusted for the specific hospital. Payment will be made on a reasonable cost basis for CAHs and coinsurance is based on charges. Payment is made under the MPFS when performed in a SNF and coinsurance is 20 percent of the lower of the actual charge or the MPFS amount. Deductible applies. **NOTE:** Effective January 1, 2005 payment will be made under MPFS for claims from hospitals subject to OPPS.
G0206	Payment will be made under OPPS for hospital outpatient departments. Coinsurance is the national unadjusted coinsurance for the APC wage adjusted for the specific hospital. Payment will be made on a reasonable cost basis for CAHs and coinsurance is based on charges. Payment is made under the MPFS when performed in a SNF. Coinsurance is 20 percent of the lower of the actual charge or the MPFS amount. Deductible applies. **NOTE:** Effective January 1, 2005 payment will be made under MPFS for claims from hospitals subject to OPPS.

Providers bill for the technical portion of screening and diagnostic mammograms on Form CMS-1450 under bill type 13X, 22X, 23X, or 85X. The professional component is billed to the carrier on Form CMS-1500 (or electronic equivalent).

Providers bill for digital screening mammographies on Form CMS-1450, utilizing revenue code 0403 and HCPCS G0202 or G0203.

Providers bill for digital diagnostic mammographies on Form CMS-1450, utilizing revenue code 0401 and HCPCS G0204, G0205, G0206 or G0207.

NOTE: Codes G0203, G0205 and G0207 are not billable codes for claims with dates of service on or after January 1, 2002.

CAHs electing the optional method of payment for outpatient services are paid according to §20.3.2.3 of this chapter.

Carrier Payment

All codes paid by the carrier are based on the Medicare Physician Fee Schedule (MPFS).

Code	Payment
G0202	Payment is the lesser of the provider's charge or the MPFS amount provided for this code in the pricing file. Part B deductible does not apply, however, coinsurance applies.
G0204	Payment is the lesser of the provider's charge or the MPFS amount provided for this code in the pricing file. Deductible and coinsurance apply.
G0206	Payment is the lesser of the provider's charge or the MPFS amount provided for this code in the pricing file. Deductible and coinsurance apply.

Contractors were furnished a mammography benefit pricing file to pay claims containing the above codes.

20.8 - Beneficiary and Provider Notices

(Rev. 1, 10-01-03)

B3-4601.4, A3-3660.10.I, SNF-537.2.G

20.8.1 - MSN Messages

(Rev. 298, Issued: 09-10-04, Effective/Implementation: 09-25-04)

B3-4601.4, A3-3660.10.I

The following messages are used on the MSN.

If the claim is denied because the beneficiary is under 35 years of age, use the following MSN:

MSN 18.3:

Screening mammography is not covered for women under 35 years of age.

The Spanish version of this MSN message should read:

Las pruebas de mamografía para mujeres menores de 35 años no están cubiertas.

If the claim is denied for a woman 35-39 because she has previously received this examination, use the following MSN:

MSN 18.6:

A screening mammography is covered only once for women age 35-39.

The Spanish version of this MSN message should read:

Una mamografía de cernimiento es cubierta una vez solamente para mujeres entre las edades de 35-39.

If the claim is denied because the period of time between screenings for the woman based on age has not passed, use the following MSN:

MSN 18.4:

This service is being denied because it has not been 12 months since your last examination of this kind. (NOTE: Insert appropriate number of months.)

The Spanish version of this MSN message should read:

Este servicio se denegó debido a que no han transcurrido 12 meses desde su último examen de este tipo.

If the claim is denied because the provider is not certified to perform this service (film mammography) or if the claim is denied because the provider is not certified to perform this service (digital mammography), use the following MSN:

MSN 16.2:

This service cannot be paid when provided in this location/facility.

The Spanish version of this MSN message should read:

Este servicio no se puede pagar cuando es suministrado en este sitio/facilidad.

In addition to the above denial messages, the FI/carrier may add the following:

MSN 18.12:

> Screening mammograms are covered annually for women 40 years of age and older.

The Spanish version of this MSN message should read:

> El examen de mamografía de cernimiento se cubre una vez al año para mujeres de 40 años de edad o más.

For Carriers only:

For claims submitted with invalid or missing certification number, use the following MSN:

MSN 9.2:

> This item or service was denied because information required to make payment was missing.

The Spanish version of this MSN message should read:

> Este artículo o servicio fue denegado porque la información requerida para hacer el pago fue omitida.

20.8.2 - Remittance Advice Messages

(Rev. 298, Issued: 09-10-04, Effective/Implementation: 09-25-04)

B3-4601.5, A3- 3660.10.J, SNF-537.I

If the claim is denied because the beneficiary is under 35 years of age, contractors must use existing ANSI X12N 835 claim adjustment reason code/message 6, “The procedure/revenue code is inconsistent with the patient’s age” along with the remark code M37 (at the line item level), “Service is not covered when the patient is under age 35.”

If the claim is denied for a woman 35-39 because she has previously received this examination, contractors must use existing ANSI X12N 835 claim adjustment reason code/message 119, “Benefit maximum for this time period or occurrence has been reached” along with the remark code M89 (at the line item level), “Not covered more than once under age 40.”

If the claim is denied for a woman age 40 and above because she has previously received this examination within the past 12 months, contractors must use existing ANSI X12N 835 claim adjustment reason code/message 119, “Benefit maximum for this time period or occurrence has been reached” along with remark code M90 (at the line item level), “Not covered more than once in a 12-month period.”

If the claim is denied because the provider that performed the screening is not certified, use existing ANSI X12N 835 claim adjustment reason code/message B7, “This provider was not certified/eligible to be paid for this procedure/service on this date of service.”

For carrier only:

For claims submitted by a facility not certified to perform film mammography, use existing reason B6, “This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty” along with remark code N110 “This facility is not certified for film mammography.”

For claims submitted by a facility not certified to perform digital mammograms, use existing reason code B6, “This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty” along with remark code N92,“This facility is not certified for digital mammography.”

For claims that were submitted with an invalid or missing certification number, use existing reason code 16, “Claim/service lacks information which is needed for adjudication” along with remark code MA128 “Missing/incomplete/invalid six-digit FDA approved, identification number.”

30 - Screening Pap Smears

(Rev. 1, 10-01-03)

A3-3628.1, B3-4603.1, B3-4603.1A, SNF-541.2

Effective January 1, 1998, §1861(nn) of the Act (42 USC 1395x(nn)) provides Medicare Part B coverage for a screening Pap smear for women under certain conditions. See the Medicare Benefit Policy Manual, Chapter 15, for coverage of screening PAP smears.

To be covered screening Pap smears must be ordered and collected by a doctor of medicine or osteopathy (as defined in §1861(r)(l) of the Act), or other authorized practitioner (e.g., a certified nurse midwife, physician assistant, nurse practitioner, or clinical nurse specialist, who is authorized under State law to perform the examination) under **one** of the conditions identified in §30.1, below.

30.1 - Pap Smears From January 1, 1998, Through June 30 2001

(Rev. 1, 10-01-03)

B3-4603.1A.1, B3-4603.1A.2, B3-4603.1A.3, A3-3628.1A

The following requirements must be met.

1. The beneficiary has not had a screening Pap smear test during the preceding three years (i.e., 35 months have passed following the month that the woman had the last covered Pap smear. Use one of the following ICD-9-CM codes V76.2, V76.47, or V76.49; **or**

2. There is evidence (on the basis of her medical history or other findings) that she is of childbearing age and has had an examination that indicated the presence of cervical or vaginal cancer or other abnormalities during any of the preceding 3 years; **and** at least 11 months have passed following the month that the last covered Pap smear was performed; **or**

3. She is at high risk of developing cervical or vaginal cancer (use ICD-9-CM code V15.89, other specified personal history presenting hazards to health) **and** at least 11 months have passed following the month that the last covered screening Pap smear was performed. The high risk factors for cervical and vaginal cancer are:

    a. Cervical Cancer High Risk Factors:

        - Early onset of sexual activity (under 16 years of age)
        - Multiple sexual partners (5 or more in a lifetime)
        - History of a sexually transmitted disease (including HIV infection)
        - Fewer than three negative or any Pap smears within the previous 7 years

    b. Vaginal Cancer High Risk Factors:

        - DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy.

NOTE: The term "woman of childbearing age" means a woman who is premenopausal, and has been determined by a physician, or qualified practitioner, to be of childbearing age, based on her medical history or other findings.

COUNTING: To determine the 11-, 23-, and 35-month periods, start counts beginning with the month after the month in which a previous test/procedure was performed.

COUNTING EXAMPLE: A beneficiary identified as being at high risk for developing cervical cancer received a screening Pap smear in January 2000. Start counts beginning with February 2000. The beneficiary is eligible to receive another screening Pap smear in January 2001 (the month after 11 full months have passed).

30.2 - Pap Smears On and After July 1, 2001

(Rev. 1, 10-01-03)

B3-4603.1.B, A3-3628.1.A.1

If the beneficiary does not qualify for more frequent screening based on paragraphs (2) and (3) above, for services performed on or after July 1, 2001, payment may be made for a screening PAP smear after 23 months have passed after the end of the month of the last covered smear. All other coverage and payment requirements remain the same.

30.3 - Deductible and Coinsurance

(Rev. 1, 10-01-03)

B3-4603.4, A3-3628.1.A.3

Neither the Part B deductible nor coinsurance apply for services paid under the laboratory fee schedule. The Part B deductible for screening Pap smear and services paid for under the physician fee schedule is waived effective January 1, 1998. Coinsurance applies.

A. Carrier Action for Submitting Claim to CWF and CWF Edit

B3-4603.4, B3-4603.6, B3-4603.1.B

When a carrier receives a claim for a screening Pap smear, performed on or after January 1, 1998, it must enter a deductible indicator of 1 (not subject to deductible) in field 67 of the HUBC record.

CWF will edit for screening pelvic examinations performed more frequently than allowed according to the presence of high risk factors.

30.4 - Payment Method

(Rev. 1, 10-01-03)

B3-4603.1.C.1 and 2

Payment may be under the clinical diagnostic lab fee schedule or the MPFS, depending upon the code billed. See the categories in §30.5 of this chapter for a description.

30.4.1 - Payment Method for RHCs and FQHCs

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

The professional component of a screening Pap smear furnished within an RHC/FQHC by a physician or non physician is considered an RHC/FQHC service. RHCs and FQHCs bill the FI under bill type 71X or 73X for the professional component along with revenue code 052X. See Chapter 9, for RHC and FQHC bill processing instructions.

The technical component of a screening Pap smear is outside the scope of the RHC/FQHC benefit. If the technical component of this service is furnished within an

independent RHC or freestanding FQHC, the provider of that technical service bills the carrier on Form CMS-1500.

If the technical component of a screening Pap smear is furnished within a provider-based RHC/FQHC, the provider of that service bills the FI under bill type 13X, 14X, 22X, 23X, or 85X as appropriate using their outpatient provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services). The appropriate revenue code is 311. *Effective 4/1/06, type of bill 14X is for non-patient laboratory specimens.*

30.5 - HCPCS Codes for Billing

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

The following HCPCS codes can be used for screening Pap smear:

A. Codes Billed to the Carrier and Paid Under the Physician Fee Schedule

The following HCPCS codes are submitted by those providers/entities that submit claims to carriers. The deductible is waived for these services effective January 1, 1998, however, coinsurance applies.

NOTE: These codes are not billed on FI claims except for HCPCS code Q0091 which may be submitted to FIs. Payment for code Q0091 performed in a hospital outpatient department is under OPPS, (see 30.5C).

- Q0091 - Screening Papanicolaou (Pap) smear, obtaining, preparing and conveyance of cervical or vaginal smear to laboratory;

- P3001 - Screening Papanicolaou smear, cervical or vaginal, up to three smears requiring interpretation by a physician;

- G0124 - Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician; and

- G0141 - Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual re-screening, requiring interpretation by physician.

B. Codes Paid Under the Clinical Lab Fee Schedule by FI and Carriers

The following codes are billed to FIs by providers they serve, or billed to carriers by the physicians/suppliers they service. Deductible and coinsurance do not apply.

- P3000 - Screening Papanicolaou smear, cervical or vaginal, up to three smears, by a technician under the physician supervision;

- G0123 - Screening cytopathology, cervical or vaginal (any reporting system) collected in preservative fluid; automated thin layer preparation, screening by cytotechnologist under physician supervision;

- G0143 - Screening cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and re-screening, by cytotechnologist under physician supervision.;

- G0144 - Screening cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system under physician supervision;

- G0145 - Screening cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual re-screening under physician supervision;

- G0147 - Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision; and

- G0148 - Screening cytopathology smears, cervical or vaginal, performed by automated system with manual reevaluation.

C. Payment of Q0091 When Billed to FIs

Payment for code Q0091 in a hospital outpatient department is under OPPS. A SNF is paid using the technical component of the MPFS. For a CAH, payment is on a reasonable cost basis. For RHC/FQHCs payment is made under the all inclusive rate for the professional component. Deductible is not applicable, however, coinsurance applies.

The technical component of a screening Pap smear is outside the RHC/FQHC benefit. If the technical component of a screening Pap smear is furnished within a provider-based RHC/FQHC, the provider of that service bills the FI under the bill type 13X, 14X,22X, 23X, or 85X as appropriate using their base provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services). For independent RHCs/FQHCs, the practitioner bills the technical component to the carrier on Form CMS-1500 or *the ANSI X12N* 837 P. *Effective 4/1/06, type of bill 14X is for non-patient laboratory specimens.*

D. Payment of Q0091 When Billed to Carriers

Payment for Q0091 is paid under the Medicare physician fee schedule. Deductible is not applicable, however the coinsurance applies.

Effective for services on and after July 1, 2005, on those occasions when physicians must perform a screening Pap smear (Q0091) that they know will not be covered by Medicare because the low risk patient has already received a covered Pap smear (Q0091) in the past 2 years, the physician can bill Q0091 and the claim will be denied appropriately. The physician shall obtain an advance beneficiary notice (ABN) in these situations as the

denial will be considered a not reasonable and necessary denial. The physician indicates on the claim that an ABN has been obtained by using the GA modifier.

Effective for services on or after April 1, 1999, a covered evaluation and management (E/M) visit and code Q0091 may be reported by the same physician for the same date of service if the E/M visit is for a separately identifiable service. In this case, the modifier "-25" must be reported with the E/M service and the medical records must clearly document the E/M reported. Both procedure codes should be shown as separate line items on the claim. These services can also be performed separately on separate office visits.

E. Common Working File (CWF) Editing for Q0091

The CWF will edit for claims containing the HCPCS code Q0091 effective for dates of service on and after July 1, 2005. Previously, the editing for Q0091 had been removed from the CWF. Medicare pays for a screening Pap smear every 2 years for low risk patients based on the low risk diagnoses, see sections 30.2 and 30.6. Medicare pays for a screening Pap smear every year for a high risk patient based on the high risk diagnosis, see sections 30.1 and 30.6. This criteria will be the CWF parameters for editing Q0091.

In those situations where unsatisfactory screening Pap smear specimens have been collected and conveyed to clinical labs that are unable to interpret the test results, another specimen will have to be collected. When the physician bills for this reconveyance, the physician should annotate the claim with Q0091 along with modifier -76, (repeat procedure by same physician).

30.6 - Diagnoses Codes

(Rev. 440, Issued: 01-21-05, Effective: 07-01-05, Implementation: 07-05-05)

Below is the current diagnoses that should be used when billing for screening Pap smear services. Effective, July 1, 2005, V72.31 is being added to the CWF edit as an additional low risk diagnosis. The following chart lists the diagnosis codes that CWF must recognize for low risk or high risk patients for screening Pap smear services.

Low Risk Diagnosis Codes	**Definitions**
V76.2	Special screening for malignant neoplasms, cervix
V76.47	Special screening for malignant neoplasm, vagina
V76.49	Special screening for malignant neoplasm, other sites **NOT**E: providers use this diagnosis for women without a cervix.
V72.31	Routine gynecological examination

Low Risk Diagnosis Codes	Definitions
	NOTE: This diagnosis should only be used when the provider performs a full gynecological examination.
High Risk Diagnosis Code	
V15.89	Other

A. Applicable Diagnoses for Billing a Carrier

There are a number of appropriate diagnosis codes that can be used in billing for screening Pap smear services that the provider can list on the claim to give a true picture of the patient's condition. Those diagnoses can be listed in Item 21 of Form CMS-1500 or the electronic equivalent (see Chapter 26 for electronic equivalent formats). In addition, one of the following diagnoses shall appear on the claim: the low risk diagnosis of V76.2, V76.47, V76.49 and (effective July 1, 2005, V72.31) or the high risk diagnosis of V15.89 (for high risk patients). One of the above diagnoses must be listed in item 21of the Form CMS-1500 or the electronic equivalent to indicate either low risk or high risk depending on the patient's condition. Then either the low risk or high risk diagnosis must also be pointed to in Item 24E of Form CMS-1500 or the electronic equivalent. Providers must make sure that for screening Pap smears for a high risk beneficiary, that the high risk diagnosis code of V15.89 appears in Item 21 and V15.89 is the appropriate diagnosis code that must be pointed to in Item 24E or the electronic equivalent. If Pap smear claims do not point to one of these specific diagnoses in Item 24E or the electronic equivalent, the claim will reject in the CWF. **Periodically, carriers should do provider education on diagnosis coding of Pap smear claims.**

If these pointers are not present on claims submitted to carriers, CWF will reject the record.

B. Applicable Diagnoses for Billing an FI

Providers report one of the following diagnosis codes in FL 67 of Form CMS-1450 or the electronic equivalent (see Chapter 25 for electronic equivalent format):

Low risk diagnosis codes:

V76.2

V76.47

V76.49

V72.31

High risk diagnosis codes

V15.89

Periodically provider education should be done on diagnosis coding of Pap Smear claims.

30.7 - Type of Bill and Revenue Codes for Form CMS-1450

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

The applicable bill types for screening Pap smears are 13X, 14X, 22X, 23X, and 85X. Use revenue code 0311 (laboratory, pathology, cytology). Report the screening pap smear as a diagnostic clinical laboratory service using one of the HCPCS codes shown in §30.5.B.

Revenue code 0928 is used for billing code Q0091. In addition, CAHs electing method II report services under revenue codes 096X, 097X, or 098X.

Effective 4/1/06, type of bill 14X is for non-patient laboratory specimens.

30.8 - MSN Messages

(Rev. 1, 10-01-03)

If there are no high risk factors, and the screening Pap smear and/or screening pelvic examination is being denied because the procedure/examination is performed more frequently than allowed use MSN 18.17:

> Medicare pays for a screening Pap smear and/or screening pelvic examination only once every (2, 3) years unless high risk factors are present.

30.9 - Remittance Advice Codes

If high risk factors are not present, and the screening Pap smear and/or screening pelvic examination is being denied because the procedure/examination is performed more frequently than allowed, use existing ANSI X12N 835:

- Claim adjustment reason code 119 - “Benefit maximum for this time period has been reached” at the line level, and
- Remark code M83 - “Service is not covered unless the patient is classified as at high risk: at the line item level.

40 - Screening Pelvic Examinations

(Rev. 1, 10-01-03)

B3-4603.2, A3-3, 3628.1B

Section 4102 of the BBA of 1997 (P.L. 105-33) amended §1861(nn) of the Act (42 USC 1395X(nn)) to include Medicare Part B coverage of screening pelvic examinations for all female beneficiaries for services provided January 1, 1998 and later. Effective July 1, 2001, the Consolidated Appropriations Act of 2001 (P.L. 106-554) modifies §1861(nn) to provide Medicare Part B coverage for biennial screening pelvic examinations. A screening pelvic examination should include at least seven of the following elements:

- Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge; and
- Digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses.

Pelvic examination (with or without specimen collection for smears and cultures) including:

- External genitalia (for example, general appearance, hair distribution, or lesions);
- Urethral meatus (for example, size, location, lesions, or prolapse);
- Urethra (for example, masses, tenderness, or scarring);
- Bladder (for example, fullness, masses, or tenderness);
- Vagina (for example, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, or rectocele);
- Cervix (for example, general appearance, lesions or discharge)
- Uterus (for example, size, contour, position, mobility, tenderness, consistency, descent, or support);
- Adnexa/parametria (for example, masses, tenderness, organomegaly, or nodularity); and
- Anus and perineum.

40.1 - Screening Pelvic Examinations From January 1, 1998, Through June 30 2001

(Rev. 1, 10-01-03)

B3-4603.2.A, B3-4603.5, A3-3628.1.B.1, R1888.A.3 Dated 6-3-2003

The following requirements must be met.

The exam must be performed by a doctor of medicine or osteopathy (as defined in **§1861(r)(1)** of the Act), or by a certified nurse midwife (as defined in **§1861(gg)** of the

Act), or a physician assistant, nurse practitioner, or clinical nurse specialist (as defined in **§1861(aa)** of the Act) who is authorized under State law to perform the examination. This examination does not have to be ordered by a physician or other authorized practitioner.

Payment may be made: Once every three years on an asymptomatic woman only if the individual has not had a screening pelvic examination paid for by Medicare during the preceding 35 months following the month in which the last Medicare-covered screening pelvic examination was performed. The provider uses one of the following ICD-9-CM codes V76.2, V76.47, or V76.49. Exceptions are as follows:

- Payment may be made for a screening pelvic examination performed more frequently than once every 35 months if the test is performed by a physician or other practitioner and there is evidence that the woman is at high risk (on the basis of her medical history or other findings) of developing cervical cancer, or vaginal cancer. (providers use ICD-9-CM code V15.89, other specified personal history presenting hazards to health.) The high risk factors for cervical and vaginal cancer are:

  Cervical Cancer High Risk Factors

  - Early onset of sexual activity (under 16 years of age)
  - Multiple sexual partners (five or more in a lifetime)
  - History of a sexually transmitted disease (including HIV infection)
  - Fewer than three negative or any Pap smears within the previous seven years

  Vaginal Cancer High Risk Factors

  - DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy.

  ICD-9-CM code V15.89, other specified personal history presenting hazards to health is used to indicate that one or more of these factors is present; or

- Payment may also be made for a screening pelvic examination performed more frequently than once every 36 months if the examination is performed by a physician or other practitioner, for a woman of childbearing age, who has had such an examination that indicated the presence of cervical or vaginal cancer or other abnormality during any of the preceding three years. The term “women of childbearing age” means a woman who is premenopausal, and has been determined by a physician, or qualified practitioner, to be of childbearing age, based on her medical history or other findings. Payment is not made for a screening pelvic examination for women at high risk or who qualify for coverage under the childbearing provision more frequently than once every 11 months after

the month that the last screening pelvic examination covered by Medicare was performed.

- For claims with dates of service on or after July 1, 2001, if the beneficiary does not qualify for an annual screening pelvic exam as noted above, pay for the screening pelvic exam only after at least 23 months have passed following the month during which the beneficiary received her last covered screening pelvic exam. All other coverage and payment requirements remain the same.

Calculating the Frequency Limitations

To determine the screening periods, start counts beginning with the month after the month in which a previous test/procedure was performed.

Frequency Limitation Example

A beneficiary identified as being at high risk for developing cervical cancer received a pelvic exam in January 2002. Start counts beginning with February 2002. The beneficiary is eligible to receive another screening exam, if high risk, in January 2003 (the month after 11 full months have passed).

40.2 - Screening Pelvic Examinations on and After July 1, 2001

(Rev. 1, 10-01-03)

B3-4603.2.B and C, A3-3628.1.B.1

When the beneficiary does not qualify for a more frequently performed screening pelvic exam noted in §40.1 of this chapter, items 2, or 3, the screening pelvic exam may be paid only after at least 23 months have passed following the month during which the beneficiary received her last covered screening pelvic exam. All other coverage and payment requirements remain the same.

A HCPCS code has been established for the pelvic and clinical breast examinations. Use code G0101 (cervical or vaginal cancer screening, pelvic and clinical breast examination).

40.3 - Deductible and Coinsurance

(Rev. 1, 10-01-03)

B3-4603.2.C, A3-3628.1.B.3

The Part B deductible for screening pelvic examinations is waived effective January 1, 1998. Coinsurance is applicable.

A. Action When Submitting Claims to CWF and CWF Edit

B3-4603.4, B3-4603.6, A3-3628.1.C.1

When a carrier receives a claim for a pelvic examination, performed on or after January 1, 1998, it must enter a deductible indicator of 1 (not subject to deductible) in field 65 of the HUBC record.

When an FI receives a claim for a screening pelvic examination (including a clinical breast examination), performed on or after January 1, 1998, it reports special override Code 1 in the "Special Action Code/Override Code" field of the CWF record for the line item, indicating the Part B deductible does not apply.

CWF edits for screening pelvic examinations performed more frequently than allowed according to the presence of high risk factors.

40.4 - Diagnoses Codes

(Rev. 440, Issued: 01-21-05, Effective: 07-01-05, Implementation: 07-05-05)

Below is the current diagnoses that should be used when billing for screening pelvic examination services. Effective, July 1, 2005, V72.31 is being added to the CWF edit as an additional low risk diagnosis. The following chart lists the diagnosis codes that CWF must recognize for low risk or high risk patients for screening pelvic examination services.

Low Risk Diagnosis Codes	**Definitions**
V76.2	Special screening for malignant neoplasm, cervix
V76.47	Special screening for malignant neoplasm, vagina
V76.49	Special screening for malignant neoplasm, other sites **NOTE**: Providers use this diagnosis for women without a cervix.
V72.31	Routine gynecological examination **NOTE**: This diagnosis should only be used when the provider performs a full gynecological examination.
High Risk Diagnosis Code	
V15.89	Other

A. Applicable Diagnoses for Billing a Carrier

There are a number of appropriate diagnosis codes that can be used in billing for screening pelvic examinations that the provider can list on the claim to give a true picture

of the patient's condition. Those diagnoses can be listed in Item 21 of Form CMS-1500 or the electronic equivalent (see Chapter 26 for electronic equivalent formats). In addition, one of the following diagnoses shall appear on the claim: the low risk diagnosis of V76.2, V76.47, V76.49 and (effective July 1, 2005, V72.31) or the high risk diagnosis of V15.89 (for high risk patients). One of the above diagnoses must be listed in item 21 to indicate either low risk or high risk depending on the patient's condition. Then either the low risk or high risk diagnosis must also be pointed to in Item 24E of Form CMS-1500 or the electronic equivalent. Providers must make sure that for screening pelvic exams for a high risk beneficiary, that the high risk diagnosis code of V15.89 appears in Item 21 and V15.89 is the appropriate diagnosis code that must be pointed to in Item 24E or electronic equivalent. If pelvic examination claims do not point to one of these specific diagnoses in Item 24E or the electronic equivalent, the claim will reject in the CWF. **Periodically, carriers should do provider education on diagnosis coding of screening pelvic examination claims.**

If these pointers are not present on claims submitted to carriers, CWF will reject the record.

B – Applicable Diagnoses for Billing an FI

Providers report one of the following diagnosis codes in FL 67 of Form CMS-1450 or the electronic equivalent (see Chapter 25 for electronic equivalent format):

Low risk diagnosis codes:

V76.2

V76.47

V76.49

V72.31

High risk diagnosis code

V15.89

Periodically provider education should be done on diagnosis coding of pelvic exam claims.

40.5 - Payment Method

(Rev 440, Issued: 01-21-05, Effective: 07-01-05, Implementation: 07-05-05)

Pelvic examinations are paid under the MPFS, whether billed to the FI or carrier **except**:

- Hospital outpatient services are paid under OPPS;

- See §40.5.B of this chapter for proper billing by RHC/FQHCs for the professional and technical components of a screening pelvic examination. RHCs/FQHCs are paid under the all-inclusive rate for the professional component; or based on the provider's payment method for the technical component;

- CAH payment is under reasonable cost.

NOTE: SNFs are paid under the MPFS and bill the FI. Physicians and other individual practitioners bill the carrier.

40.6 - Revenue Code and HCPCS Codes for Billing

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

A. Billing to the Carrier

Code G0101 (cervical or vaginal cancer screening, pelvic and clinical breast examination) is used.

Effective for services on or after January 1, 1999, a covered evaluation and management (E/M) visit and code G0101 may be reported by the same physician for the same date of service if the E/M visit is for a separately identifiable service. In this case, the modifier "-25" must be reported with the E/M service and the medical records must clearly document the E/M service reported. Both procedure codes should be shown as separate line items on the claim. These services can also be performed separately on separate office visits.

B. Billing to the FI

The applicable bill types for a screening pelvic examination (including breast examination) are 13X, ~~*14X,*~~ 22X, 23X, and 85X. The applicable revenue code is 0770. (See §70.1.1.2 for RHCs and FQHCs.) *Effective 4/1/06, type of bill 14X is for non-patient laboratory specimens and is no longer applicable for a screening pelvic examination.*

The professional component of a screening pelvic examination furnished within an RHC/FQHC by a physician or non-physician is considered an RHC/FQHC service. RHCs and FQHCs bill the FI under bill type 71X or 73X for the professional component along with revenue code 052X.

The technical component of a screening pelvic examination is outside the scope of the RHC/FQHC benefit. If the technical component of this service is furnished within an independent RHC or freestanding FQHC, the provider of that technical service bills the carrier on *ANSI X12N 837 P or hardcopy Form CMS-1500.*

> If the technical component of a screening pelvic examination is furnished within a provider-based RHC/FQHC, the provider of that service bills the FI under bill type 13X, ~~*14X,*~~ 22X, 23X, or 85X as appropriate using their outpatient provider number (not the RHC/FQHC provider number since

these services are not covered as RHC/FQHC services). The appropriate revenue code is 0770. *Effective 4/1/06, type of bill 14X is for non-patient laboratory specimens and is no longer applicable for a screening pelvic examination.*

40.7 - MSN Messages

(Rev. 440, Issued: 01-21-05, Effective: 07-01-05, Implementation: 07-05-05)

If there are no high risk factors, and the screening Pap smear and/or screening pelvic examination is being denied because the procedure/examination is performed more frequently than allowed, contractors use MSN 18-17:

- Medicare pays for a screening Pap smear and/or screening pelvic examination only once every (2, 3) years unless high risk factors are present.

40.8 - Remittance Advice Codes

(Rev. 440, Issued: 01-21-05, Effective: 07-01-05, Implementation: 07-05-05)

If high risk factors are not present, and the screening Pap smear and/or screening pelvic examination is being denied because the procedure/examination is performed more frequently than allowed, use existing ANSI X12N 835:

- Claim adjustment reason code 119 - "Benefit maximum for this time period has been reached" at the line level, and

Remark code M83 - "Service is not covered unless the patient is classified as at high risk." At the line item level.

50 - Prostate Cancer Screening Tests and Procedures

(Rev. 1, 10-01-03)

B3-4182, A3-3616

Sections 1861(s)(2)(P) and 1861(oo) of the Act (as added by §4103 of the Balanced Budget Act of 1997), provide for Medicare Part B coverage of certain prostate cancer screening tests subject to certain coverage, frequency, and payment limitations. Effective for services furnished on or after January 1, 2000, Medicare Part B covers prostate cancer screening tests/procedures for the early detection of prostate cancer. Coverage of prostate cancer screening tests includes the following procedures furnished to an individual for the early detection of prostate cancer:

- Screening digital rectal examination, and
- Screening prostate specific antigen (PSA) blood test.

Each test may be paid at a frequency of once every 12 months for men who have attained age 50 (i.e., starting at least one day after they have attained age 50), if at least 11 months have passed following the month in which the last Medicare-covered screening digital rectal examination was performed (for digital rectal exams) or PSA test was performed (for PSA tests).

50.1 - Definitions

(Rev. 1, 10-01-03)

A3-3616.A.1 and 2

A. Screening Digital Rectal Examination

Screening digital rectal examination means a clinical examination of an individual's prostate for nodules or other abnormalities of the prostate. This screening must be performed by a doctor of medicine or osteopathy (as defined in §186l(r)(1) of the Act), or by a physician assistant, nurse practitioner, clinical nurse specialist, or by a certified nurse mid-wife (as defined in §1861(aa) and §1861(gg) of the Act), who is authorized under State law to perform the examination, fully knowledgeable about the beneficiary, and would be responsible for explaining the results of the examination to the beneficiary.

B. Screening Prostate Specific Antigen (PSA) Tests

Screening prostate specific antigen (PSA) is a test that measures the level of prostate specific antigen in an individual's blood. This screening must be ordered by the beneficiary's physician or by the beneficiary's physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife (the term "physician" is defined in §1861(r)(1) of the Act to mean a doctor of medicine or osteopathy and the terms "physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife" are defined in §1861(aa) and §1861(gg) of the Act) who is fully knowledgeable about the beneficiary, and who would be responsible for explaining the results of the test to the beneficiary.

50.2 - Deductible and Coinsurance

(Rev. 1, 10-01-03)

B3-4182.3

The screening PSA test is a lab test to which neither deductible nor coinsurance apply.

Both deductible (if unmet) and coinsurance are applicable to screening rectal examinations.

50.3 - Payment Method - FIs and Carriers

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

Screening PSA tests (G0103) are paid under the clinical diagnostic lab fee schedule.

Screening rectal examinations (G0102) are paid under the MPFS except for the following bill types identified (FI only). Bill types not identified are paid under the MPFS.

12X = Outpatient Prospective Payment System

13X = Outpatient Prospective Payment System

14X-=Outpatient Prospective Payment System

71X = Included in All Inclusive Rate

73X = Included in All Inclusive Rate

85X = Cost (Payment should be consistent with amounts paid for code 84153 or code 86316.)

Effective 4/1/06 the type of bill 14X is for non-patient laboratory specimens.

The RHCs and FQHCs should include the charges on the claims for future inclusion in encounter rate calculations.

50.3.1 - Correct Coding Requirements for Carrier Claims

(Rev. 1, 10-01-03)

B3-4182.6

Billing and payment for a Digital Rectal Exam (DRE) (G0102) is bundled into the payment for a covered E/M service (CPT codes 99201 - 99456 and 99499) when the two services are furnished to a patient on the same day. If the DRE is the only service or is provided as part of an otherwise noncovered service, HCPCS code G0102 would be payable separately if all other coverage requirements are met.

50.4 - HCPCS, Revenue, and Type of Service Codes

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

The appropriate bill types for billing the FI on Form CMS-1450 or its electronic equivalent are 12X, 13X, 14X,22X, 23X, 71X, 73X, 75X, and 85X. *Effective 4/1/06, type of bill 14X is for non-patient laboratory specimens.*

The HCPCS code G0102 - for prostate cancer screening digital rectal examination.

- Carrier TOS is 1
- FI revenue code is 0770

The HCPCS code G0103 - for prostate cancer screening PSA tests

- Carrier TOS is 5
- FI revenue code is 030X

50.5 - Diagnosis Coding

(Rev. 1, 10-01-03)

B3-4182.7

Prostate cancer screening digital rectal examinations and screening Prostate Specific Antigen (PSA) blood tests must be billed using screening ("V") code V76.44 (Special Screening for Malignant Neoplasms, Prostate).

50.6 - Calculating Frequency

(Rev. 1, 10-01-03)

A3-3616.D and E, B3-4182.4, B3-4182.5

Calculating Frequency - To determine the 11-month period, the count starts beginning with the month after the month in which a previous test/procedure was performed.

EXAMPLE: The beneficiary received a screening prostate specific antigen test in January 2002. Start counts beginning February 2002. The beneficiary is eligible to receive another screening prostate specific antigen test in January 2003 (the month after 11 months have passed).

Common Working File (CWF) Edits

Beginning October 1, 2000, the following CWF edits were implemented for dates of service January 1, 2000, and later, for prostate cancer screening tests and procedures for the following:

- Age;
- Frequency;
- Sex; and
- Valid HCPCS code.

50.7 - MSN Messages

(Rev. 1, 10-01-03)

B3-4182.8.B, A3-3616.F

If a claim for screening prostate specific antigen test or a screening digital rectal examination is being denied because of the age of the beneficiary, FIs use MSN message 18.13:

> This service is not covered for patients under 50 years of age.

The Spanish version of this MSN message should read:

> Este servicio no está cubierto hasta después de que el beneficiario cumpla 50 años.

Carriers use MSN Message 18.19:

> This service is not covered until after the patient's 50th birthday.

The Spanish version of this MSN message should read:

> Este servicio no está cubierto hasta después de que el beneficiario cumpla 50 años.

If the claim for screening prostate specific antigen test or screening digital rectal examination is being denied because the time period between the same test or procedure has not passed, FIs and carriers use MSN message 18.14:

> Service is being denied because it has not been 12 months since your last test/procedure) of this kind.

The Spanish version of this MSN message should read:

> Este servicio está siendo denegado ya que no han transcurrido (12, 24, 48) meses desde el último (examen/procedimiento) de esta clase.

50.8 - Remittance Advice Notices

(Rev. 1, 10-01-03)

B3-4182.8, A3-3616.G

If the claim for a screening prostate antigen test or screening digital rectal examination is being denied because the patient is less than 50 years of age, ANSI X12N 835.

- Claim adjustment reason code 6 "the procedure/revenue code is inconsistent with the patient's age," at the line level; and
- Remark code M140 "Service is not covered until after the patient's 50th birthday, i.e., no coverage prior to the day after the 50th birthday."

If the claim for a screening prostate specific antigen test or screening digital rectal examination is being denied because the time period between the test/procedure has not

passed, contractors use ANSI X12N 835 claim adjustment reason code 119 “Benefit maximum for this time period has been reached” at the line level.

If the claim for a screening prostate antigen test or screening digital rectal examination is being denied due to the absence of diagnosis code V76.44 on the claim, use ANSI X12N 835 claim adjustment reason code 47, “This (these) diagnosis(es) is (are) not covered, missing, or invalid.”

51 – Cryosurgery of the Prostate Gland

(Rev. 260, Issued 07-30-04, Effective: 01-01-05/Implementation: 01-03-05)

Cryosurgery of the prostate gland, also known as cryosurgical ablation of the prostate (CAP), destroys prostate tissue by applying extremely cold temperatures in order to reduce the size of the prostate gland.

51.1 - Coverage Requirements

(Rev. 260, Issued 07-30-04, Effective: 01-01-05/Implementation: 01-03-05)

Medicare covers cryosurgery of the prostate gland effective for claims with dates of service on or after July 1, 1999. The coverage is for:

1. Primary treatment of patients with clinically localized prostate cancer, Stages T1 – T3 (diagnosis code is 185 – malignant neoplasm of prostate).

2. Salvage therapy (effective for claims with dates of service on or after July 1, 2001 for patients:

    a. Having recurrent, localized prostate cancer;

    b. Failing a trial of radiation therapy as their primary treatment; and

    c. Meeting one of these conditions: State T2B or below; Gleason score less than 9 or; PSA less than 8 ng/ml.

51.2 - Billing Requirements

(Rev. 260, Issued 07-30-04, Effective: 01-01-05/Implementation: 01-03-05)

Claims for cryosurgery for the prostate gland are to be submitted on Form CMS – 1450 or electronic equivalent. This procedure can be rendered in an inpatient or outpatient hospital setting (types of bill (TOB) 11x 13x, 83x, and 85x).

The FI will look for the following when processing claims with cryosurgery services:

- Diagnosis Code 185 (must be on all cryosurgical claims);

- For outpatient claims HCPCS 55873 and revenue code 0361, Cryosurgery ablation of localized prostate cancer, stages T1- T3 (includes ultrasonic guidance for interstital cryosurgery probe placement, postoperative irrigations and aspiration of sloughing tissue included) must be on all outpatient claims; and

- For inpatient claims procedure code 60.62 (perineal prostatectomy- the definition includes cryoablation of prostate, cryostatectomy of prostate, and radical cryosurgical ablation of prostate) must be on the claim.

51.3 – Payment Requirements

(Rev. 260, Issued 07-30-04, Effective: 01-01-05/Implementation: 01-03-05)

This service may be paid as a primary treatment for patients with clinically localized prostate cancer, Stages T1 – T3. The ultrasonic guidance associated with this procedure will not be paid for separately, but is bundled into the payment for the surgical procedure. When one provider has furnished the cryosurgical ablation and another the ultrasonic guidance, the provider of the ultrasonic guidance must seek compensation from the provider of the cryosurgical ablation.

Effective July 1, 2001, cryosurgery performed as salvage therapy, will be paid only according to the coverage requirements described above.

Type of facility and setting determines the basis of payment:

- For services performed on an inpatient or outpatient basis in a CAH, TOBs 11x and 85x: the FI will pay 101 percent of reasonable cost minus any applicable deductible and coinsurance.

- For services performed on an inpatient basis in short term acute care hospitals, (including those in Guam, America Samoa, Virgin Islands, Saipan, and Indian Health Services Hospitals) TOB 11x: the FI will pay the DRG payment minus any applicable deductible and coinsurance.

- For services performed on an outpatient basis in hospitals subject to the Outpatient PPS, TOB 13x: the FI will pay the assigned APC minus any applicable deductible and coinsurance.

- For outpatient services in hospitals that are exempt from OPPS (such as in American Samoa, Virgin Islands, Guam, and Saipan) TOBs 13x or 83x: the FI will pay reasonable cost subject to the ASC payment limitation for TOB 83x, minus any applicable deductible and coinsurance.

- For outpatient services in Indian Health Service hospitals TOBs 13x and 83x: the FI will pay reasonable cost subject to the ASC payment limitation for TOB 83x. minus any applicable deductible and coinsurance.

- For inpatient or outpatient services in hospitals in Maryland, make payment according to the State Cost Containment system.

For services performed on an inpatient basis: the hospitals exempt from inpatient acute care PPS shall be paid on reasonable cost basis, minus any applicable deductible and coinsurance.

60 - Colorectal Cancer Screening

(Rev. 52, 12-19-03)

B3-4180, B3-4180.6, A3-3660.17

See the Medicare Benefit Policy Manual, Chapter 1, for Medicare Part B coverage and effective dates of colorectal rectal screening services.

Effective for services furnished on or after January 1, 1998, payment may be made for colorectal cancer screening for the early detection of cancer. For screening colonoscopy services (one of the types of services included in this benefit) prior to July 2001, coverage was limited to high-risk individuals. For services July 1, 2001, and later screening colonoscopies are covered for individuals not at high risk.

The following services are considered colorectal cancer screening services:

- Fecal-occult blood test, 1-3 simultaneous determinations (guaiac-based);
- Flexible sigmoidoscopy;
- Colonoscopy; and,
- Barium enema

Effective for services on or after January 1, 2004, payment may be made for the following colorectal cancer screening service as an alternative for the guaiac-based fecal-occult blood test, 1-3 simultaneous determinations:

- Fecal-occult blood test, immunoassay, 1-3 simultaneous determinations

60.1 - Payment

(Rev. 52, 12-19-03)

Payment (carrier and FI) is under the MPFS except as follows:

- Fecal occult blood tests (G0107 and G0328) are paid under the clinical diagnostic lab fee schedule except reasonable cost is paid to CAHs;

- Flexible sigmoidoscopy (code G0104) is paid under OPPS for hospital outpatient departments and on a reasonable cost basis for CAHs; or

- Colonoscopy (G0105) and barium enemas (G0106 and G0120) are paid under OPPS for hospital outpatient departments and on a reasonable costs basis for CAHs. There is no beneficiary liability for CAH services. Also colonoscopies may be done in an Ambulatory Surgical Center (ASC) and when done in an ASC the ASC rate applies. The ASC rate is the same for diagnostic and screening colonoscopies.

The following screening codes must be paid at rates consistent with the diagnostic codes indicated.

Screening Code	**Diagnostic Code**
G0104	45330
G0105 and G0121	45378
G0106	74280
G0120	74280

60.2 - HCPCS Codes, Frequency Requirements, and Age Requirements (If Applicable)

(Rev. 52, 12-19-03)

B3-4180.2, A3-3660.17.A, AB-03-114

Effective for services furnished on or after January 1, 1998, the following codes are used for colorectal cancer screening services:

- G0107 - Colorectal cancer screening; fecal-occult blood tests, 1-3 simultaneous determinations;

- G0104 - Colorectal cancer screening; flexible sigmoidoscopy;

- G0105 - Colorectal cancer screening; colonoscopy on individual at high risk;

- G0106 - Colorectal cancer screening; barium enema; as an alternative to G0104, screening sigmoidoscopy;

- G0120 - Colorectal cancer screening; barium enema; as an alternative to G0105, screening colonoscopy.

Effective for services furnished on or after July 1, 2001 the following codes are used for colorectal cancer screening services:

- G0121 - Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk. Note that the description for this code has been revised to remove the term "noncovered."

- G0122 - Colorectal cancer screening; barium enema (noncovered).

Effective for services furnished on or after January 1, 2004, the following code is used for colorectal cancer screening services as an alternative to G0107:

- G0328 - Colorectal cancer screening; immunoassay, fecal-occult blood test, 1-3 simultaneous determinations

G0104 - Colorectal Cancer Screening; Flexible Sigmoidoscopy

Screening flexible sigmoidoscopies (code G0104) may be paid for beneficiaries who have attained age 50, when performed by a doctor of medicine or osteopathy at the frequencies noted below.

For claims with dates of service on or after January 1, 2002, contractors pay for screening flexible sigmoidoscopies (code G0104) for beneficiaries who have attained age 50 when these services were performed by a doctor of medicine or osteopathy, or by a physician assistant, nurse practitioner, or clinical nurse specialist (as defined in §1861(aa)(5) of the Act and in the Code of Federal Regulations at 42 CFR 410.74, 410.75, and 410.76) at the frequencies noted above. For claims with dates of service prior to January 1, 2002, contractors pay for these services under the conditions noted only when a doctor of medicine or osteopathy performs them.

For services furnished from January 1, 1998, through June 30, 2001, inclusive:

- Once every 48 months (i.e., at least 47 months have passed following the month in which the last covered screening flexible sigmoidoscopy was done).\

For services furnished on or after July 1, 2001:

- Once every 48 months as calculated above **unless** the beneficiary does not meet the criteria for high risk of developing colorectal cancer (refer to §60.2 of this chapter) **and** he/she has had a screening colonoscopy (code G0121) within the preceding 10 years. If such a beneficiary has had a screening colonoscopy within the preceding 10 years, then he or she can have covered a screening flexible sigmoidoscopy only after at least 119 months have passed following the month that he/she received the screening colonoscopy (code G0121).

NOTE: If during the course of a screening flexible sigmoidoscopy a lesion or growth is detected which results in a biopsy or removal of the growth; the appropriate diagnostic procedure classified as a flexible sigmoidoscopy with biopsy or removal should be billed and paid rather than code G0104.

G0105 - Colorectal Cancer Screening; Colonoscopy on Individual at High Risk

Ref: AB-03-114

Screening colonoscopies (code G0105) may be paid when performed by a doctor of medicine or osteopathy at a frequency of once every 24 months for beneficiaries at high risk for developing colorectal cancer (i.e., at least 23 months have passed following the month in which the last covered G0105 screening colonoscopy was performed). Refer to §60.2 of this chapter for the criteria to use in determining whether or not an individual is at high risk for developing colorectal cancer.

NOTE: If during the course of the screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal should be billed and paid rather than code G0105.

A. Colonoscopy Cannot be Completed Because of Extenuating Circumstances

1. FIs

When a covered colonoscopy is attempted but cannot be completed because of extenuating circumstances, Medicare will pay for the interrupted colonoscopy as long as the coverage conditions are met for the incomplete procedure. However, the frequency standards associated with screening colonoscopies will not be applied by CWF. When a covered colonoscopy is next attempted and completed, Medicare will pay for that colonoscopy according to its payment methodology for this procedure as long as coverage conditions are met, and the frequency standards will be applied by CWF. This policy is applied to both screening and diagnostic colonoscopies. When submitting a facility claim for the interrupted colonoscopy, providers are to suffix the colonoscopy HCPCS codes with a modifier of "–73" or" –74" as appropriate to indicate that the procedure was interrupted. Payment for covered incomplete screening colonoscopies shall be consistent with payment methodologies currently in place for complete screening colonoscopies, including those contained in 42 CFR 419.44(b). In situations where a critical access hospital (CAH) has elected payment Method II for CAH patients, payment shall be consistent with payment methodologies currently in place as outlined in Chapter 3. As such, instruct CAHs that elect Method II payment to use modifier "–53" to identify an incomplete screening colonoscopy (physician professional service(s) billed in revenue code 096X, 097X, and/or 098X). Such CAHs will also bill the technical or facility component of the interrupted colonoscopy in revenue code 075X (or other appropriate revenue code) using the "-73" or "-74" modifier as appropriate.

Note that Medicare would expect the provider to maintain adequate information in the patient's medical record in case it is needed by the contractor to document the incomplete procedure.

2. Carriers

When a covered colonoscopy is attempted but cannot be completed because of extenuating circumstances (see Chapter 12), Medicare will pay for the interrupted colonoscopy at a rate consistent with that of a flexible sigmoidoscopy as long as coverage conditions are met for the incomplete procedure. When a covered colonoscopy is next attempted and completed, Medicare will pay for that colonoscopy according to its payment methodology for this procedure as long as coverage conditions are met. This policy is applied to both screening and diagnostic colonoscopies. When submitting a claim for the interrupted colonoscopy, professional providers are to suffix the colonoscopy code with a modifier of "–53" to indicate that the procedure was interrupted. When submitting a claim for the facility fee associated with this procedure, Ambulatory Surgical Centers (ASCs) are to suffix the colonoscopy code with "–73" or "–74" as appropriate. Payment for covered screening colonoscopies, including that for the associated ASC facility fee when applicable, shall be consistent with payment for diagnostic colonoscopies, whether the procedure is complete or incomplete.

Note that Medicare would expect the provider to maintain adequate information in the patient's medical record in case it is needed by the contractor to document the incomplete procedure.

G0106 - Colorectal Cancer Screening; Barium Enema; as an Alternative to G0104, Screening Sigmoidoscopy

Screening barium enema examinations may be paid as an alternative to a screening sigmoidoscopy (code G0104). The same frequency parameters for screening sigmoidoscopies (see those codes above) apply.

In the case of an individual aged 50 or over, payment may be made for a screening barium enema examination (code G0106) performed after at least 47 months have passed following the month in which the last screening barium enema or screening flexible sigmoidoscopy was performed. For example, the beneficiary received a screening barium enema examination as an alternative to a screening flexible sigmoidoscopy in January 1999. Start counts beginning February 1999. The beneficiary is eligible for another screening barium enema in January 2003.

The screening barium enema must be ordered in writing after a determination that the test is the appropriate screening test. Generally, it is expected that this will be a screening double contrast enema unless the individual is unable to withstand such an exam. This means that in the case of a particular individual, the attending physician must determine that the estimated screening potential for the barium enema is equal to or greater than the screening potential that has been estimated for a screening flexible sigmoidoscopy for the same individual. The screening single contrast barium enema also requires a written order from the beneficiary's attending physician in the same manner as described above for the screening double contrast barium enema examination.

G0107 - Colorectal Cancer Screening; Fecal-Occult Blood Test, 1-3 Simultaneous Determinations

Effective for services furnished on or after January 1, 1998, screening FOBT (code G0107) may be paid for beneficiaries who have attained age 50, and at a frequency of once every 12 months (i.e., at least 11 months have passed following the month in which the last covered screening FOBT was performed). This screening FOBT means a guaiac-based test for peroxidase activity, in which the beneficiary completes it by taking samples from two different sites of three consecutive stools. This screening requires a written order from the beneficiary's attending physician. (The term "attending physician" is defined to mean a doctor of medicine or osteopathy (as defined in §1861(r)(1) of the Act) who is fully knowledgeable about the beneficiary's medical condition, and who would be responsible for using the results of any examination performed in the overall management of the beneficiary's specific medical problem.)

Effective for services furnished on or after January 1, 2004, payment may be made for a immunoassay-based FOBT (G0328, described below) as an alternative to the guaiac-based FOBT, G0107. Medicare will pay for only one covered FOBT per year, either G0107 or G0328, but not both.

G0328 - Colorectal Cancer Screening; Immunoassay, Fecal-Occult Blood Test, 1-3 Simultaneous Determinations

Effective for services furnished on or after January 1, 2004, screening FOBT, (code G0328) may be paid as an alternative to G0107 for beneficiaries who have attained age 50. Medicare will pay for a covered FOBT (either G0107 or G0328, but not both) at a frequency of once every 12 months (i.e., at least 11 months have passed following the month in which the last covered screening FOBT was performed). Screening FOBT, immunoassay, includes the use of a spatula to collect the appropriate number of samples or the use of a special brush for the collection of samples, as determined by the individual manufacturer's instructions. This screening requires a written order from the beneficiary's attending physician. (The term "attending physician" is defined to mean a doctor of medicine or osteopathy (as defined in §1861(r)(1) of the Act) who is fully knowledgeable about the beneficiary's medical condition, and who would be responsible for using the results of any examination performed in the overall management of the beneficiary's specific medical problem.)

G0120 - Colorectal Cancer Screening; Barium Enema; as an Alternative to or G0105, Screening Colonoscopy

Screening barium enema examinations may be paid as an alternative to a screening colonoscopy (code G0105) examination. The same frequency parameters for screening colonoscopies (see those codes above) apply.

In the case of an individual who is at high risk for colorectal cancer, payment may be made for a screening barium enema examination (code G0120) performed after at least 23 months have passed following the month in which the last screening barium enema or the last screening colonoscopy was performed. For example, a beneficiary at high risk for developing colorectal cancer received a screening barium enema examination (code G0120) as an alternative to a screening colonoscopy (code G0105) in January 2000. Start

counts beginning February 2000. The beneficiary is eligible for another screening barium enema examination (code G0120) in January 2002.

The screening barium enema must be ordered in writing after a determination that the test is the appropriate screening test. Generally, it is expected that this will be a screening double contrast enema unless the individual is unable to withstand such an exam. This means that in the case of a particular individual, the attending physician must determine that the estimated screening potential for the barium enema is equal to or greater than the screening potential that has been estimated for a screening colonoscopy, for the same individual. The screening single contrast barium enema also requires a written order from the beneficiary's attending physician in the same manner as described above for the screening double contrast barium enema examination.

G0121 - Colorectal Screening; Colonoscopy on Individual Not Meeting Criteria for High Risk - Applicable On and After July 1, 2001

Effective for services furnished on or after July 1, 2001, screening colonoscopies (code G0121) performed on individuals not meeting the criteria for being at high risk for developing colorectal cancer (refer to §60.2 of this chapter) may be paid under the following conditions:

- At a frequency of once every 10 years (i.e., at least 119 months have passed following the month in which the last covered G0121 screening colonoscopy was performed.)

- If the individual would otherwise qualify to have covered a G0121 screening colonoscopy based on the above **but** has had a covered screening flexible sigmoidoscopy (code G0104), then he or she may have covered a G0121 screening colonoscopy only after at least 47 months have passed following the month in which the last covered G0104 flexible sigmoidoscopy was performed.

NOTE: If during the course of the screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal should be billed and paid rather than code G0121.

G0122 - Colorectal Cancer Screening; Barium Enema

The code is not covered by Medicare.

60.2.1 - Common Working Files (CWF) Edits

(Rev. 544, Issued: 04-29-05, Effective: 10-01-05, Implementation: 10-03-05)

Effective for dates of service January 1, 1998, and later, CWF will edit all claims for colorectal screening for age and frequency standards. The CWF will also edit FI claims for valid procedure codes (G0104, G0105, G0106, G0107, G0120, G0121, G0122, and G0328) for valid bill types. The CWF currently edits for valid HCPCS codes for carriers. Effective for dates of service January 1, 2004, and later, CWF will edit all claims for

colorectal cancer screening code G0328 for age and frequency standards. (See §60.6 of this chapter for bill types.)

60.2.2 - Ambulatory Surgical Center (ASC) Facility Fee

(Rev. 1, 10-01-03)

A3 0 3660.17.K, B3-4180.10

CPT code 45378, which is used to code a diagnostic colonoscopy, is on the list of procedures approved by Medicare for payment of an ambulatory surgical center facility under §1833(I) of the Act. CPT code 45378 is currently assigned to ASC payment group 2. Code G0105, colorectal cancer screening; colonoscopy on individuals at high risk, was added to the ASC list effective for services furnished on or after January 1, 1998. Code G0121, colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk, was added to the ASC list effective for services furnished on or after July 1, 2001. Codes G0105 and G0121 are assigned to ASC payment group 2. The ASC facility service is the same whether the procedure is a screening or a diagnostic colonoscopy. If during the course of the screening colonoscopy performed at an ASC, a lesion or growth is detected which results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal should be billed rather than code G0105.

60.3 - Determining High Risk for Developing Colorectal Cancer

(Rev. 1, 10-01-03)

B3-4180.3, A3-3660.17, HO-456.B

A. Characteristics of the High Risk Individual

An individual at high risk for developing colorectal cancer has one or more of the following:

- A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp;
- A family history of familial adenomatous polyposis;
- A family history of hereditary nonpolyposis colorectal cancer;
- A personal history of adenomatous polyps;
- A personal history of colorectal cancer; or
- Inflammatory bowel disease, including Crohn’s Disease, and ulcerative colitis.

B. Partial List of ICD-9-CM Codes Indicating High Risk

Listed below are some examples of diagnoses that meet the high-risk criteria for colorectal cancer. This is not an all-inclusive list. There may be more instances of conditions, which may be coded and could be considered high risk at the medical directors' discretion.

Personal History	
V10.05	Personal history of malignant neoplasm of large intestine
V10.06	Personal history of malignant neoplasm of rectum, rectosigmoid junction, and anus
Chronic Digestive Disease Condition:	
555.0	Regional enteritis of small intestine
555.1	Regional enteritis of large intestine
555.2	Regional enteritis of small intestine with large intestine
555.9	Regional enteritis of unspecified site
556.0	Ulcerative (chronic) enterocolitis
556.1	Ulcerative (chronic) ileocolitis
556.2	Ulcerative (chronic) proctitis
556.3	Ulcerative (chronic) proctosigmoiditis
556.8	Other ulcerative colitis
556.9	Ulcerative colitis, unspecified (non-specific PDX on the MCE)
Inflammatory Bowel:	
558.2	Toxic gastroenteritis and colitis
558.9	Other and unspecified non-infectious gastroenteritis and colitis

60.4 - Determining Frequency Standards

(Rev. 1, 10-01-03)

B3-4180.4, A3-3660.17.D, HO-456.D

To determine the 11, 23, 47, and 119 month periods, start counts beginning with the month after the month in which a previous test/procedure was performed.

EXAMPLE: The beneficiary received a fecal-occult blood test in January 2000. Start counts beginning with February 2000. The beneficiary is eligible to receive another blood test in January 2001 (the month after 11 full months have passed).

60.5 - Noncovered Services

(Rev. 1, 10-01-03)

B3-4180.5, A3-3660.17, HO-456.C

The following noncovered HCPCS codes are used to allow claims to be billed and denied for beneficiaries who need a Medicare denial for other insurance purposes for the dates of service indicated:

A. From January 1, 1998 Through June 30, 2001, Inclusive

Code G0121 (colorectal cancer screening; colonoscopy on an individual not meeting criteria for high risk) should be used when this procedure is performed on a beneficiary who does **not** meet the criteria for high risk. This service should be denied as noncovered because it fails to meet the requirements of the benefit for these dates of service. The beneficiary is liable for payment. Note that this code is a covered service for dates of service on or after July 1, 2001.

B. On or After January 1, 1998

Code G0122 (colorectal cancer screening; barium enema) should be used when a screening barium enema is performed **not** as an alternative to either a screening colonoscopy (code G0105) or a screening flexible sigmoidoscopy (code G0104). This service should be denied as noncovered because it fails to meet the requirements of the benefit. The beneficiary is liable for payment.

60.6 - Billing Requirements for Claims Submitted to FIs

(Rev. 80, 02-06-04)

A3-3660.17.E and G

Follow the general bill review instructions in Chapter 25. Providers bill the FI on Form CMS-1450 using bill type 13X, 22X, 23X, 83X, or 85X. In addition, the hospital bills revenue codes and HCPCS codes as follows:

Screening Test/Procedure	Revenue Code	HCPCS Code
Occult blood test	030X	G0107, G0328

Screening Test/Procedure	Revenue Code	HCPCS Code
Barium enema	032X	G0106, G0120, G0122
Flexible Sigmoidoscopy	*	G0104
Colonoscopy-high risk	*	G0105, G0121
* The appropriate revenue code when reporting any other surgical procedure for bill types 13X, 83X, or 85X and revenue code 075X for bill types 22X or 23X.		

A. Special Billing Instructions for Hospital Inpatients

When these tests/procedures are provided to inpatients of a hospital, they are covered under this benefit. However, the provider bills on bill type 13X using the discharge date of the hospital stay to avoid editing in the Common Working File (CWF) as a result of the hospital bundling rules.

60.7 - MSN Messages

(Rev. 52, 12-19-03)

B3-4180.8, A3-3660.17I, HO-456.I

The following MSN messages are used (See Chapter 21 for the Spanish versions of these messages):

A. If a claim for a screening fecal-occult blood test, a screening flexible sigmoidoscopy, or a barium enema is being denied because of the age of the beneficiary, MSN message 18.13 is used.

> This service is not covered for patients under 50 years of age.

B. If the claim for a screening fecal-occult blood test, a screening colonoscopy, a screening flexible sigmoidoscopy, or a barium enema is being denied because the time period between the same test or procedure has not passed, MSN message 18.14 is used:

Service is being denied because it has not been (12, 24, 48, 120) months since your last (test/procedure) of this kind.

C. If the claim is being denied for a screening colonoscopy or a barium enema because the beneficiary is not at a high risk, MSN message 18.15 is used:

> Medicare covers this procedure only for patients considered to be at a high risk for colorectal cancer.

D. If the claim is being denied because payment has already been made for a screening fecal-occult blood test (G0107 or G0328), flexible sigmoidoscopy (code G0104), screening colonoscopy (code G0105), or a screening barium enema (codes G0106 or G0120), MSN message 18.16 is used:

> This service is denied because payment has already been made for a similar procedure within a set timeframe.

NOTE: MSN message 18-16 should only be used when a certain screening procedure is performed as an alternative to another screening procedure. For example: If the claims history indicates a payment has been made for code G0120 and an incoming claim is submitted for code G0105 within 24 months, the incoming claim should be denied.

E. If the claim is being denied for a noncovered screening procedure code such as G0122, the following MSN message 16.10 is used:

> Medicare does not pay for this item or service.

If an invalid procedure code is reported, the contractor will return the claim as unprocessable to the provider under current procedures.

60.8 - Remittance Advice Notices

(Rev. 1, 10-01-03)

B3-4180.9, A3-3660.17.J, HO-456.J

All messages refer to ANSI X12N 835 coding.

A. If the claim for a screening fecal-occult blood test, a screening flexible sigmoidoscopy, or a screening barium enema is being denied because the patient is less than 50 years of age, use:

- Claim adjustment reason code 6 “the procedure code is inconsistent with the patient’s age,” at the line level; and
- Remark code M82 “Service is not covered when patient is under age 50.” at the line level.

B. If the claim for a screening fecal-occult blood test, a screening colonoscopy, a screening flexible sigmoidoscopy, or a screening barium enema is being denied because the time period between the test/procedure has not passed, use:

- Reason code 119 “Benefit maximum for this time period has been reached” at the line level.

C. If the claim is being denied for a screening colonoscopy (code G0105) or a screening barium enema (G0120) because the patient is not at a high risk, use:

- Claim adjustment reason code 46 “This (these) service(s) is (are) not covered” at the line level; and

- Remark code M83 “Service is not covered unless the patient is classified as a high risk.” at the line level.

D. If the service is being denied because payment has already been made for a similar procedure within the set time frame, use:

- Claim adjustment reason code 18, “Duplicate claim/service” at the line level; and

- Remark code M86 “Service is denied because payment already made for similar procedure within a set timeframe.” at the line level.

E. If the claim is being denied for a noncovered screening procedure such as G0122, use:

- Claim adjustment reason code 49, “These are noncovered services because this is a routine exam or screening procedure done in conjunction with a routine exam.”

F. If the claim is being denied because the code is invalid, use the following at the line level:

Claim adjustment reason code B18 “Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.”

70 - Glaucoma Screening Services

(Rev. 1, 10-01-03)

B3-4184

Conditions of Medicare Part B coverage for glaucoma screening are located in the Medicare Benefit Policy Manual, Chapter 15.

70.1 - Claims Submission Requirements and Applicable HCPCS Codes

(Rev. 1, 10-01-03)

B3-4184.2, A-01-105 (CR 1783), B-01-46 (CR 1717), A-01-132(CR 1914)

Claims for screening for glaucoma should be submitted on Form CMS-1500 to carriers and Form CMS-1450 to FIs or their electronic equivalents. Claims must be prepared and submitted by physicians and providers to the carrier in accordance with the general instructions in Chapter 26. Claims submitted to FIs must be prepared in accordance with the general bill instructions in Chapter 25.

70.1.1 - HCPCS and Diagnosis Coding

(Rev. 1, 10-01-03)

B3-4184.2, A-01-105 (CR 1783), B-01-46 (CR 1717), A-01-132(CR 1914)

The following HCPCS codes should be reported when billing for screening glaucoma services:

> G0117 - Glaucoma screening for high-risk patients furnished by an optometrist (physician for carrier) or ophthalmologist.
>
> G0118 - Glaucoma screening for high-risk patients furnished under the direct supervision of an optometrist (physician for carrier) or ophthalmologist.

The carrier claims type of service for the above G codes is: TOS Q.

Glaucoma screening claims should be billed using screening ("V") code V80.1 (Special Screening for Neurological, Eye, and Ear Diseases, Glaucoma). Claims submitted without a screening diagnosis code may be returned to the provider as unprocessable (refer to Chapter 1 for more information about incomplete or invalid claims).

70.1.1.1 - Additional Coding Applicable to Claims Submitted to FIs

(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

A. Type of Bill

The applicable FI claim bill types for screening glaucoma services are 13X, 22X, 23X, 71X, 73X, 75X, and 85X. (See instructions below for rural health clinics (RHCs) and federally qualified health centers (FQHCs).)

B. Revenue Coding

The following revenue codes should be reported when billing for screening glaucoma services: Comprehensive outpatient rehabilitation facilities (CORFs), critical access hospitals (CAHs), and skilled nursing facilities (SNFs) bill for this service under revenue code 0770. CAHs electing the optional method of payment for outpatient services also report this service under revenue codes 096X, 097X, or 098X. Hospital outpatient departments bill for this service under any valid/appropriate revenue code. They are not required to report revenue code 0770. (See instructions below for RHCs and FQHCs.)

70.1.1.2 - Special Billing Instructions for RHCs and FQHCs

(Rev. 371, Issued 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

Screening glaucoma services are considered RHC/FQHC services. For claims with dates of service before April 1, 2005, RHCs and FQHCs bill the FI under bill type 71X or 73X along with revenue code 0770 and HCPCS codes G0117 or G0118 and RHC/FQHC revenue code 0520 or 0521 to report the related visit. Reporting of revenue code 0770

and HCPCS codes G0117 and G0118 in addition to revenue code 0520 or 0521 is required for this service in order for CWF to perform frequency editing. Payment should not be made for a screening glaucoma service unless the claim also contains a visit code for the service. FIs must edit to assure payment is not made for revenue code 0770. The claim must also contain a visit revenue code (0520 or 0521). Payment is made for the screening glaucoma service under the all-inclusive rate for the line item reporting revenue code 0520 or 0521. No payment is made on the line item reporting revenue code 0770.

Screening glaucoma services furnished within an RHC/FQHC by a physician or nonphysician are considered RHC/FQHC services. For claims with dates of service on or after April 1, 2005, RHCs and FQHCs bill the FI under bill type 71X or 73X for the service. Payment is made under the all-inclusive rate. Additional revenue and HCPCS coding is no longer required for this service when RHCs/FQHCs are billing for the service. Use revenue code 0520 or 0521, as appropriate.

70.1.2 - Edits

(Rev. 1, 10-01-03)

B3-4184.4, A-01-132 (CR 1914), B3-4184.5

A. Common Working File Edits

Effective January 1, 2002, CWF edits glaucoma screening claims for frequency and valid HCPCS codes for dates of service January 1, 2002, and later.

B. Claims Edits

Nationwide claims processing edits for pre or post payment review of claim(s) for glaucoma screening are not required at this time. Carriers and FIs monitor claims to assure that they are paid only for covered individuals and perform medical review as appropriate. Local medical review policies and edits may be developed for such claims.

70.2 - Payment Methodology

(Rev. 1, 10-01-03)

B3-4184.7, A-01-132 (CR 1914), A-01-105(CR 1783), B-01-46 (CR 1717)

Carriers pay for glaucoma screening based on the Medicare Physician Fee Schedule. Deductible and coinsurance apply. Claims from physicians or other providers where assignment was not taken are subject to the Medicare limiting charge, which means they cannot charge the beneficiary more than 115 percent of the allowed amount.

FI pay the facility expense as follows:

- Independent and provider-based RHC/free standing and provider-based FQHC receive payment under the all-inclusive rate for the screening glaucoma service based on the visit furnished to the RHC/FQHC patient;

- CAHs receive payment on a reasonable cost basis unless the CAH has elected the optional method of payment for outpatient services in which case, procedures outlined in Chapter 4 should be followed;

- CORFs receive payment under the Medicare Physician Fee Schedule;

- Hospital outpatient departments receive payment under the outpatient prospective payment system (OPPS);

- Hospital inpatient Part B services are paid under OPPS;

- SNF outpatient services are paid under the Medicare physician fee schedule (MPFS); and

- SNF inpatient Part B services are paid under MPFS.

Deductible and coinsurance apply.

70.3 - Determining the 11-Month Period

(Rev. 1, 10-01-03)

A-01-132 (CR 1914), B3-4184.3

Once a beneficiary has received a covered glaucoma screening procedure, the beneficiary may receive another procedure after 11 full months have passed. To determine the 11-month period, start counts beginning with the month after the month in which the previous covered screening procedure was performed.

70.4 - Remittance Advice Notices

(Rev. 895, Issued: 03-24-06; Effective: 01-01-06; Implementation: 04-03-06)

Appropriate remittance advice(s) must be used *by fiscal intermediaries and carriers* when denying payment for glaucoma screening. The following messages are used where applicable:

- If the services were furnished before January 1, 2002, use existing ANSI X12N 835 remittance advice claim adjustment reason code 26 “Expenses incurred prior to coverage” at the line level.

- If the claim for glaucoma screening is being denied because the minimum time period has not elapsed since the performance of the same Medicare covered procedure, use

existing ANSI X12N 835 claim adjustment reason code 119 “Benefit maximum for this time period has been reached” at the line level.

- If the service is being denied because the individual is not an African-American age 50 or over, use existing remittance advice claim adjustment reason code 6, “The procedure code is inconsistent with the patient’s age,” and existing remark codes M83, “Service not covered unless the patient is classified as at high risk,” and M82, “Service not covered when patient is under age 50.” Report these codes at the line level.

- *If the service is being denied because the individual is not a Hispanic-American age 65 or over, use existing remittance advice claim adjustment reason code 96, “Non-covered charge,” and existing remark codes M83, “Service not covered unless the patient is classified as at high risk,” and N129, "This amount represents the dollar amount not eligible due to patient's age."*

- If the service is being denied because the patient does not have diabetes *mellitus,* or there is no family history of *glaucoma*, carriers use existing remittance advice claim adjustment reason code B5, “Payment adjusted because coverage/program guidelines were not met or were exceeded.” The zero payment for the service will indicate the denial. In addition, report remark code M83, “Service is not covered unless the patient is classified as at high risk” at the line level.

70.5 - MSN Messages

(Rev. 895, Issued: 03-24-06; Effective: 01-01-06; Implementation: 04-03-06)

The following MSN messages where appropriate must be used.

If a claim for a screening for glaucoma is being denied because the service was performed prior to January 1, 2002, use the MSN message:

MSN Message 16.54:

> This service is not covered prior to January 1, 2002.

The Spanish version of the MSN message should read:

> Este servicio no está cubierto antes del 1 de enero de 2002.

If a claim for screening for glaucoma is being denied because the minimum time period has not elapsed since the performance of the same Medicare-covered procedure, use MSN message:

MSN Message 18.14:

> Service is being denied because it has not been [12/24/48] months since your last [test/procedure] of this kind.

The Spanish version of this MSN message should read:

> Este servicio está siendo denegado ya que no han transcurrido [12, 24, 48] meses desde el último[examen/procedimiento] de esta clase.

If a claim for a screening for glaucoma is being denied because the age-related and/or ethnic-related coverage criteria are not met, use:

MSN Message 21.21:

> *This service was denied because Medicare only covers this service under certain circumstances.*

The Spanish version of this MSN message should read:

> *Este servicio fue denegado porque Medicare solamente lo cubre bajo ciertas circunstancias.*

80 – Initial Preventive Physical Examination (IPPE)

(Rev. 417, Issued: 12-22-04, Effective: 01-01-05, Implementation: 01-03-05)

Background: Effective for services furnished on or after January 1, 2005, Section 611 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) provides for coverage under Part B of one initial preventive physical examination (IPPE) for new beneficiaries only, subject to certain eligibility and other limitations. We amended §§411.15 (a)(1) and 411.15 (k)(11) of the Code of Federal Regulations (CFR) to permit payment for an IPPE as described at 42 CFR §410.16, added by 69 FR 66236, 66420 (November 15, 2004) not later than 6 months after the date the individual's first coverage period begins under Medicare Part B.

For the physician/practitioner billing correct coding policy, refer to Publication 100-04, Chapter 12, section 30.6.1.1.

The IPPE may be performed by a doctor of medicine or osteopathy as defined in section 1861 (r)(1) of the Social Security Act (the Act) or by a qualified mid-level nonphysician practitioner (NPP) (nurse practitioner, physician assistant or clinical nurse specialist), not later than 6 months after the date the individual's first coverage begins under Medicare Part B. (See section 80.3 for a list of bill types of facilities that can bill fiscal intermediaries (FIs) for this service.) This examination will include: (1) review of the individual's medical and social history with attention to modifiable risk factors for disease detection, (2) review of the individual's potential (risk factors) for depression or other mood disorders, (3) review of the individual's functional ability and level of safety; (4) a physical examination to include measurement of the individual's height, weight, blood pressure, a visual acuity screen, and other factors as deemed appropriate by the examining physician or qualified nonphysician practitioner (NPP), (5) performance and interpretation of an electrocardiogram (EKG); (6) education, counseling, and referral, as deemed appropriate, based on the results of the review and evaluation services described

in the previous 5 elements, and (7) education, counseling, and referral including a brief written plan (e.g., a checklist or alternative) provided to the individual for obtaining the appropriate screening and other preventive services, which are separately covered under Medicare Part B benefits. The EKG performed as a component of the IPPE will be billed separately. Medicare will pay for only one IPPE per beneficiary per lifetime. The Common Working File (CWF) will edit for this benefit.

As required by statute, the total IPPE service includes an EKG, but the EKG is billed with its own unique HCPCS code(s). The IPPE does not include other preventive services that are currently separately covered and paid under section 1861 of the Act under Medicare Part B screening benefits. (That is, pneumococcal, influenza and hepatitis B vaccines and their administration, screening mammography, screening pap smear and screening pelvic examinations, prostate cancer screening tests, colorectal cancer screening tests, diabetes outpatient self-management training services, bone mass measurements, glaucoma screening, medical nutrition therapy for individuals with diabetes or renal disease, cardiovascular screening blood tests, and diabetes screening tests.)

80.1 – HCPCS Coding for the IPPE

(Rev. 417, Issued: 12-22-04, Effective: 01-01-05, Implementation: 01-03-05)

The following new HCPCS codes have been developed for the IPPE benefit:

G0344: Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 6 months of Medicare enrollment

Short Descriptor: Initial Preventive Exam

G0366: Electrocardiogram, routine ECG with 12 leads; performed as a component of the initial preventive examination with interpretation and report

Short Descriptor: EKG for initial prevent exam

G0367: tracing only, without interpretation and report, performed as a component of the initial preventive examination

Short Descriptor: EKG tracing for initial prev

G0368: interpretation and report only, performed as a component of the initial preventive examination

Short Descriptor: EKG interpret & report preve

80.2 – Carrier Billing Requirements:

(Rev. 417, Issued: 12-22-04, Effective: 01-01-05, Implementation: 01-03-05)

Effective for dates of service on and after January 1, 2005, carriers shall recognize the above new HCPCS codes for IPPE. The type of service (TOS) for each of the new codes is as follows:

G0344: TOS = 1
G0366: TOS = 5
G0367: TOS = 5
G0368: TOS = 5

Carriers shall pay physicians or qualified nonphysician practitioners for only one IPPE performed not later than 6 months after the date the individual's first coverage begins under Medicare Part B, but only if that coverage period begins on or after January 1, 2005.

Carriers shall allow payment for a medically necessary Evaluation and Management (E/M) service at the same visit as the IPPE when it is clinically appropriate. Physicians and qualified nonphysician practitioners shall use CPT codes 99201 - 99215 to report an E/M with CPT modifier 25 to indicate that the E/M is a separately identifiable service from the G0344. Refer to Publication 100-04, Chapter 12, Section 30.6.1.1, for the physician/practitioner billing correct coding policy regarding E/M services.

If the EKG performed as a component of the IPPE is not performed by the primary physician or qualified NPP during the IPPE visit, another physician or entity may perform and/or interpret the EKG. The referring provider needs to make sure that the performing provider bills the appropriate G code for the screening EKG, and **not** a CPT code in the 93000 series. **Both the IPPE and the EKG should be billed in order for the beneficiary to receive the complete IPPE service.**

Should the same physician or NPP need to perform an additional medically necessary EKG in the 93000 series on the same day as the IPPE, the provider should report the appropriate EKG CPT code(s) with modifier 59, indicating that the EKG is a distinct procedural service.

Physicians or qualified nonphysician practitioners shall bill the carrier the appropriate HCPCS codes for IPPE on the Form CMS-1500 claim or an approved electronic format. The new HCPCS codes are paid under the Medicare Physician Fee Schedule (MPFS). The appropriate deductible and coinsurance applies.

80.3 – Fiscal Intermediary Billing Requirements:

(Rev. 417, Issued: 12-22-04, Effective: 01-01-05, Implementation: 01-03-05)

The FI will pay for IPPE or EKG only when the services are submitted on one of the following type bills (TOB): 12X, 13X, 22X, 71X, 73X and 85X.

Type of facility and setting determines the basis of payment:

- For services performed on a 12X and 13X, for hospitals subject to the outpatient prospective payment system (OPPS), under the OPPS. Hospitals not subject to OPPS shall be paid under current methodologies.

- For services performed on an 85X TOB, Critical Access Hospitals, pay on reasonable cost.

- For services performed in a SNF, TOB 22x, make payment for the technical component of the EKG based on the MPFS.

- For inpatient or outpatient services in hospitals in Maryland, make payment according to the State Cost Containment System.

80.3.1 – RHC/FQHCs Special Billing Instructions

(Rev. 417, Issued: 12-22-04, Effective: 01-01-05, Implementation: 01-03-05)

Payment for the professional services will be made under the all-inclusive rate. Encounters with more than one health professional and multiple encounters with the same health professionals that take place on the same day and at a single location constitute a single visit. Beneficiary CWF records will not be updated to reflect the new G code when the IPPE is provided in an RHC/FQHC.

The technical component of the EKG performed at independent RHC/FQHC is billed to Medicare carriers on professional claims (Form CMS 1500 or 837P). The technical component of the EKG performed at a provider-based RHC\FQHC is billed on the applicable TOB and submitted to the FI using the base provider number.

80.3.2 – Indian Health Services (IHS) Hospitals Special Billing Instructions

(Rev. 417, Issued: 12-22-04, Effective: 01-01-05, Implementation: 01-03-05)

The designated FI pays IHS hospitals when G0344 is submitted; this includes the IPPE whether or not the EKG is performed at the same time. The designated FI will also pay IHS hospitals for the EKG if HCPCS code G0367 is present. For the professional component of the EKG, the designated carrier shall pay the billing physician or other practitioner the established amount.

80.3.3 - OPPS Hospital Billing

(Rev. 516, Issued: 04-01-05, Effective: 01-01-05, Implementation: 10-03-05)

Hospitals subject to OPPS (TOBs 12X and 13X) must use modifier 25 when billing the IPPE G0344 along with technical component of the EKG, G0367, on the same claim. This is due to an Outpatient Prospective Payment System (OPPS) Outpatient Code Editor (OCE) which contains an edit that requires a modifier 25 on any evaluation and management (E/M) HCPCS code if there is also a status "S" or "T" HCPCS procedure code on the claim.

80.4 – Coinsurance and Deductible

(Rev. 417, Issued: 12-22-04, Effective: 01-01-05, Implementation: 01-03-05)

The MMA did not make any provision for the waiver of the Medicare coinsurance and Part B deductible for the IPPE. Payment for this service would be applied to the required deductible if the deductible has not been met, with the exception of FQHCs, and the usual coinsurance provisions would apply to all providers.

The FQHC encounter is exempt from deductible. The contractors shall apply coinsurance and deductible to payments for the IPPE except for payments by the FI to FQHCs where only co-insurance applies.

80.5 – Medicare Summary Notices (MSNs)

(Rev. 417, Issued: 12-22-04, Effective: 01-01-05, Implementation: 01-03-05)

When denying additional claims for G0344, G0366, G0367 and G0368, contractors shall use MSN 18.22 - This service was denied because Medicare only covers the one-time initial preventive physical exam with an electrocardiogram within the first six months that you have Part B coverage, and only if that coverage begins on or after January 1, 2005.

The Spanish version is: 18.22 - Este servicio fue denegado porque Medicare solamente cubre un examen fisico preventivo con un electrocardiograma dentro de los primeros 6 meses que usted tenga cobertura de la Parte B, y sólo si esta cobertura comienza en o después del 1 de enero de 2005.

80.6 – Remittance Advice Remark Codes

(Rev. 417, Issued: 12-22-04, Effective: 01-01-05, Implementation: 01-03-05)

Contractors shall use the appropriate claim Remittance Advice Remark code, such as N117 (This service is paid only once in a patient's lifetime) when denying additional claims for G0344, G0366, G0367 and G0368.

80.7 – Claims Adjustment Reason Codes

(Rev. 417, Issued: 12-22-04, Effective: 01-01-05, Implementation: 01-03-05)

Contractors shall use the appropriate Claim Adjustment Reason code, such as 149 (Lifetime benefit maximum has been reached for this service/benefit category) when denying additional claims for G0344, G0366, G0367 and G0368.

80.8 – Advanced Beneficiary Notice (ABN) as Applied to the IPPE

(Rev. 516, Issued: 04-01-05, Effective: 01-01-05, Implementation: 10-03-05)

If a second IPPE is billed for the same beneficiary, it would be denied based on section 1861(s)(2) of the Act, since the IPPE is a one-time benefit, and an ABN would not be required in order to hold the beneficiary liable for the cost of the second IPPE. However, an ABN should be issued for all IPPEs conducted after the beneficiary's statutory 6-month period has lapsed since based on 1862(a)(1)(K), Medicare is statutorily prohibited from paying for an IPPE outside the initial 6-month period.

90 - Diabetes Screening

(Rev. 457, Issued: 01-28-05, Effective: 04-01-05, Implementation: 04-04-05)

90.1 - HCPCS Coding for Diabetes Screening

(Rev. 457, Issued: 01-28-05, Effective: 04-01-05, Implementation: 04-04-05)

The following HCPCS codes are to be billed for diabetes screening:

82947 – Glucose, quantitative, blood (except reagent strip)

82950 – post-glucose dose (includes glucose)

82951 – tolerance test (GTT), three specimens (includes glucose)

90.2 - Carrier Billing Requirements

(Rev. 457, Issued: 01-28-05, Effective: 04-01-05, Implementation: 04-04-05)

Effective for dates of service January 1, 2005 and later, carriers shall recognize the above HCPCS codes for diabetes screening.

Carriers shall pay for diabetes screening once every 12 months for a beneficiary that is not pre-diabetic. Carriers shall pay for diabetes screening at a frequency of once every 6 months for a beneficiary that meets the definition of pre-diabetes.

A claim that is submitted for diabetes screening by a physician or supplier for a beneficiary that does not meet the definition of pre-diabetes shall be submitted in the following manner:

The line item shall contain 82947, 82950 or 82951 with a diagnosis code of V77.1 reported in the header.

90.2.1 - Modifier Requirements for Pre-diabetes

(Rev. 457, Issued: 01-28-05, Effective: 04-01-05, Implementation: 04-04-05)

A claim that is submitted for diabetes screening and the beneficiary meets the definition of pre-diabetes shall be submitted in the following manner:

The line item shall contain 82497, 82950 or 82951 with a diagnosis code of V77.1 reported in the header. In addition, modifier "TS" (follow-up service) – shall be reported on the line item.

90.3 - Fiscal Intermediary (FI) Billing Requirements

(Rev. 457, Issued: 01-28-05, Effective: 04-01-05, Implementation: 04-04-05)

Effective for dates of service January 1, 2005 and later, FIs shall recognize the above HCPCS codes for diabetes screening.

FIs shall pay for diabetes screening once every 12 months for a beneficiary that is not pre-diabetic. FIs shall pay for diabetes screening at a frequency of once every 6 months for a beneficiary that meets the definition of pre-diabetes.

A claim that is submitted for diabetes screening by a physician or supplier for a beneficiary that does not meet the definition of pre-diabetes shall be submitted in the following manner:

The line item shall contain 82947, 82950 or 82951 with a diagnosis code of V77.1.

90.3.1 - Modifier Requirements for Pre-diabetes

(Rev. 457, Issued: 01-28-05, Effective: 04-01-05, Implementation: 04-04-05)

A claim that is submitted for diabetes screening and the beneficiary meets the definition of pre-diabetes shall be submitted in the following manner:

The line item shall contain 82497, 82950 or 82951 with a diagnosis code of V77.1. In addition, modifier "TS" (follow-up service) – shall be reported on the line item.

90.4 - Diagnosis Code Reporting

(Rev. 457, Issued: 01-28-05, Effective: 04-01-05, Implementation: 04-04-05)

A claim that is submitted for diabetes screening shall include the diagnosis code V77.1.

90.5 - Medicare Summary Notices

(Rev. 457, Issued: 01-28-05, Effective: 04-01-05, Implementation: 04-04-05)

When denying claims for diabetes screening based upon a CWF reject for 82947, 82950 or 82951 reported with diagnosis code V77.1, contractors shall use MSN 18.4, "This service is being denied because it has not been 6 months since your last examination of this kind." (See chapter 30 section 40.3.6.4(c) for additional information on ABN's.)

90.6 - Remittance Advice Remark Codes

(Rev. 457, Issued: 01-28-05, Effective: 04-01-05, Implementation: 04-04-05)

Contractors shall use the appropriate remittance advice notice that appropriately explains the denial of payment.

90.7 - Claims Adjustment Reason Codes

(Rev. 457, Issued: 01-28-05, Effective: 04-01-05, Implementation: 04-04-05)

Contractors shall use the appropriate claims adjustment reason code such as 119 "Benefit maximum for this time period or occurrence has been reached."

100 – Cardiovascular Disease Screening

(Rev. 408, Issued: 12-17-04, Effective: 01-01-05, Implementation: 01-03-05)

100.1 – HCPCS Coding for Cardiovascular Disease Screening

(Rev. 408, Issued: 12-17-04, Effective: 01-01-05, Implementation: 01-03-05)

The following HCPCS codes are to be billed for Cardiovascular Disease Screening:

80061 – Lipid Panel

82465 – Cholesterol, serum or whole blood, total

83718 – Lipoprotein, direct measurement, high density cholesterol

84478 – Triglycerides

100.2 – Carrier Billing Requirements

(Rev. 408, Issued: 12-17-04, Effective: 01-01-05, Implementation: 01-03-05)

Effective for dates of service, January 1, 2005, and later, carriers shall recognize the above HCPCS codes for Cardiovascular Disease Screening.
Carriers shall pay for Cardiovascular Disease Screening once every 60 months.

A claim that is submitted for Cardiovascular Disease Screening shall be submitted in the following manner:

The line item shall contain 80061, 82465, 83718 or 84478 with a diagnosis code of V81.0 – Special screening for ischemic heart disease, V81.1 – Special screening for hypertension or V81.2 – Special screening for other and unspecified cardiovascular conditions reported in the header and pointed to the line item.

100.3 – Fiscal Intermediary (FI) Billing Requirements

(Rev. 408, Issued: 12-17-04, Effective: 01-01-05, Implementation: 01-03-05)

Effective for dates of service, January 1, 2005, and later, intermediaries shall recognize the above HCPCS codes for Cardiovascular Disease Screening.

FIs shall pay for Cardiovascular Disease Screening once every 60 months.

A claim that is submitted for Cardiovascular Disease Screening shall be submitted in the following manner:
The line item shall contain 80061, 82465, 83718 or 84478 with a diagnosis code of V81.0 – Special screening for ischemic heart disease, V81.1 – Special screening for hypertension or V81.2 – Special screening for other and unspecified cardiovascular conditions reported in the header and pointed to the line item.

100.4 – Diagnosis Code Reporting

(Rev. 408, Issued: 12-17-04, Effective: 01-01-05, Implementation: 01-03-05)

A claim that is submitted for Cardiovascular Disease Screening shall be submitted with one or more of the following diagnosis codes in the header and pointed to the line item:

V81.0 – Special screening for ischemic heart disease,
V81.1 – Special screening for hypertension, or
V81.2 – Special screening for other and unspecified cardiovascular conditions

100.5 – Medicare Summary Notice

(Rev. 408, Issued: 12-17-04, Effective: 01-01-05, Implementation: 01-03-05)

When denying claims for cardiovascular screening based upon a CWF reject for 80061, 82465, 83718, or 84478 billed with one or more the following diagnosis codes V81.0, V81.1 and V81.2, contractors shall use MSN 16.54 Medicare does not pay for this many services or supplies.

100.6 – Remittance Advice Remark Codes

(Rev. 408, Issued: 12-17-04, Effective: 01-01-05, Implementation: 01-03-05)

Contractors shall use the appropriate remittance advice notice that appropriately explains the denial of payment.

100.7 – Claim Adjustment Reason Code

(Rev. 408, Issued: 12-17-04, Effective: 01-01-05, Implementation: 01-03-05)

Contractors shall use claims adjustment reason code 119 “Benefit maximum for this time period has been reached.”